

# Increasing Access to Tobacco Cessation in States

- ActionToQuit Case Studies -

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May 2011

Partnership for Prevention is a nonprofit organization dedicated to preventing illness and injury and promoting health. Partnership's programs reach policymakers, a wide range of public health and healthcare professionals, businesses, and others who can emphasize prevention.

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# **Acknowledgements**

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**Partnership for Prevention** recognizes the following lead organizations who were awarded 2010 ActionToQuit state grants and contributed their case studies to *Increasing Access to Tobacco Cessation in States*.

**American Lung Association in Florida**

**American Lung Association in Nevada**

**American Lung Association of New England**

**Colorado Tobacco Education and Prevention Alliance**

**New York State Smokers' Quitline**

**Prevention Connections**

**Partnership for Prevention** would like to acknowledge and thank Pfizer Foundation, Pfizer Inc and the Global Health Partnerships Program for their commitment to tobacco control worldwide and for the grant that enables Partnership to move the ActionToQuit initiative forward. It would not be possible without this generous funding. The contents of this publication do not necessarily reflect the viewpoints of Pfizer Foundation, Pfizer Inc or the Global Health Partnerships program.



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# Foreword

Partnership for Prevention seeks to create a “prevention culture” in America, where the prevention of disease and the promotion of health, based on the best scientific evidence, is the first priority for policy makers, decision-makers, and practitioners. ActionToQuit is Partnership’s tobacco control initiative that urges all sectors – employers, insurers, health care systems, quitlines, and policymakers – to work together to ensure that all tobacco users have access to comprehensive cessation treatments.

The ActionToQuit State Grant Program was implemented by Partnership for Prevention in 2010 with funding from the Pfizer Foundation and Pfizer Inc. The program aims to dramatically increase access to and use of proven tobacco cessation treatments. The focus of the ActionToQuit State Grants is system and policy change in tobacco cessation which will be accomplished through the strengthening of state level alliances for tobacco cessation. These alliances will chart a course for increasing coverage for these services in States, strengthen quitlines, work with health systems/employers/insurers, and promote the importance of tobacco cessation. As a result, utilization of these treatments will increase and tobacco use will decline.

Jud Richland, MPH  
President and CEO, Partnership for Prevention

# Introduction

Partnership for Prevention (PFP) funded six state tobacco cessation alliances to engage in capacity-building for enhanced tobacco cessation services: Colorado, Florida, Nevada, New England, New York and Virginia. In Year 01, each state was to assemble resources that would enable the alliance to hold a state summit meeting about tobacco cessation services and to develop an action plan that would guide the alliance in the future. The project began in April 2010 and the first task was for representatives from the six funded state alliances to attend the kick-off grantee meeting in Washington DC. PFP established a subcontract with the Prevention and Community Health department in the School of Public Health and Health Services at The George Washington University for the evaluation services of Caroline Sparks, Ph.D., who has a long history of work on tobacco control initiatives. Dr. Sparks attended the initial meeting of state grantees and then worked with PFP staff and grantees to refine a program logic model to guide the program. PFP held a round of telephone conferences with grantees to discuss each state's activities for Year 01. Each grantee submitted a state logic model based on the general PFP program logic model.

The capacity-building program logic model was focused on inputs, intervention activities and outputs, but not on outcomes. However, the model defined immediate program outcomes related to changes in social norms regarding tobacco cessation enhancement, intermediate changes in access and use of services, and changes in policies and procedures related to cessation coverage, and finally long-range health improvements. In the initial discussions with grantees, it became clear that each state alliance wanted to ask questions of participants in their summit meeting. PFP staff, the evaluator, and the state grantees agreed to collaborate in asking the same questions across states. Dr. Sparks helped PFP develop a survey questionnaire that moved the ActionToQuit program forward toward evaluating immediate program outcomes. It served as a baseline survey to assess social norms about tobacco cessation services, the importance of the issue, priorities for action, barriers to improvement, intent to serve as advocates for cessation services, self-efficacy as advocates, and perceptions of their state alliance to serve as advocates for enhanced services among participants. PFP distributed the survey on a SurveyMonkey platform to the alliances who, in turn, distributed it to all people who had registered for the state summits. Responses were anonymous. The evaluator, with the help of graduate students in public health, then analyzed the information and presented the preliminary results at the second grantee meeting in February 2011.

As part of the program evaluation, each state alliance has submitted a year-end case study, which are presented in this guide. These case studies are attached. The case study format follows the program logic model. After a brief overview and an environmental scan of the conditions in their state, state alliance staff review their achievements related to their goals and objectives for the year. They report on the resources they needed and assembled, the activities and outputs of their capacity-building intervention, and then describe the challenges and lessons learned. Each report includes a section on how the state alliance overcame challenges and what their plans are for Year 02.

- **Resources:** Each state alliance, including the six states in New England, developed Executive Committees to guide their summit planning. The state reports make it clear that the funding from Pfizer, via PFP, was most important in facilitating summit meetings. Most states supplemented this award with other funding

or in-kind contributions from partners in their alliances. New York, for example, held three summits in the state relying especially upon a variety of resources to hold a summit in New York City in fall 2010.

Executive committees found many creative ways to reach people from various sectors of the health and business world. Several had a particularly hard time recruiting people from businesses and insurance companies. Some alliances hired consultants to help plan and facilitate their summits. Efforts to employ social media for recruiting had mixed results, but Florida reported excellent success in using a website called Grouply.com.

- **Activities:** Each state alliance successfully held a state summit and some states held multiple meetings. The New England alliance of six states had the hardest time scheduling and recruiting meetings partially due to winter weather and the various agendas of different states. In general, all states had attendees from a variety of health sectors including for-profit and non-profit agencies, state government agencies, insurers, Medicaid agencies, health providers and quit lines. Summit meetings were usually an entire day with invited speakers and educational events in the mornings and planning groups in the afternoon. The planning groups focused on generating priorities and strategies for the state action plans.
- **Outputs:** The outputs of the summit meetings were the outlines for state action plans, most of which are now progressing toward written reports to guide state activities. Most alliances expect to publish the action plans by summer 2011. Other outputs included the creation of various web pages and educational materials. Meetings with officials in various state governments are also planned as follow-up activities to the summits. The Executive Committees in each state will continue to guide the implementation of the state action plans.
- **Challenges:** The biggest challenge mentioned in the state reports was how to advocate for better cessation services when faced with large budget cuts to tobacco control programs by state legislatures all over the U.S. One state lost all state funding for tobacco control. Agencies are losing staff and non-profits are affected by cuts in funding as well. In addition, with the passage of health reform, some states are focused on getting exemption from the law. State alliances had to delay summit planning in order to cope with threats to tobacco control that they had not expected.

The other challenge most often mentioned was the difficulty in getting business leaders and insurers to attend the summit meetings. People on Executive Committees relied on personal contacts and a network of contacts within their states to try to attract more people from these sectors. Again, the uncertainty about how the new health care law would affect employers and insurance companies had an effect on their willingness to consider new employee benefits.

Expanding Medicaid coverage for cessation or quit line services were the other areas of difficulty. State alliance members expressed their on-going commitment to try to increase access and to find resources to educate the public about services that do exist. Massachusetts had a particularly strong program that could serve as a model for other state alliances.

Overcoming these challenges took ingenuity and persistence from alliance members. Since many have a long history of working on tobacco control, they are used to finding creative ways to do things with limited resources. Someone reported: down but not out, which likely summarizes many of the other sentiments regarding funding cuts and other difficulties.

- **Lessons Learned and Future Plans:** The New York alliance included a helpful list of key lessons learned that apply to many observations in alliance reports:
  - Don't do it alone!
  - Develop a website for communication
  - An organized and diverse Executive Committee is a must
  - Schedule bi-weekly conference calls and create a standing agenda
  - Delegate tasks with a checklist and form sub-committees
  - Build on each person's strengths
  - Leverage resources
  - Anticipate unexpected costs
  - Don't make assumptions

Virginia was successful in recruiting by asking organizations for letters of support and a commitment to attend the summit. Colorado emphasized the importance of tackling reform and interpreting its implications for the state. Florida found that media attention extended beyond the summit to cessation in general as an issue. Nevada suggested letting businesses know that even in a recession cessation access has a positive impact on business. Several states strongly praised their experience with professional consultants to implement the summit meetings and keep things moving smoothly. New England states reported a variety of lessons learned, depending on the conditions in each state.

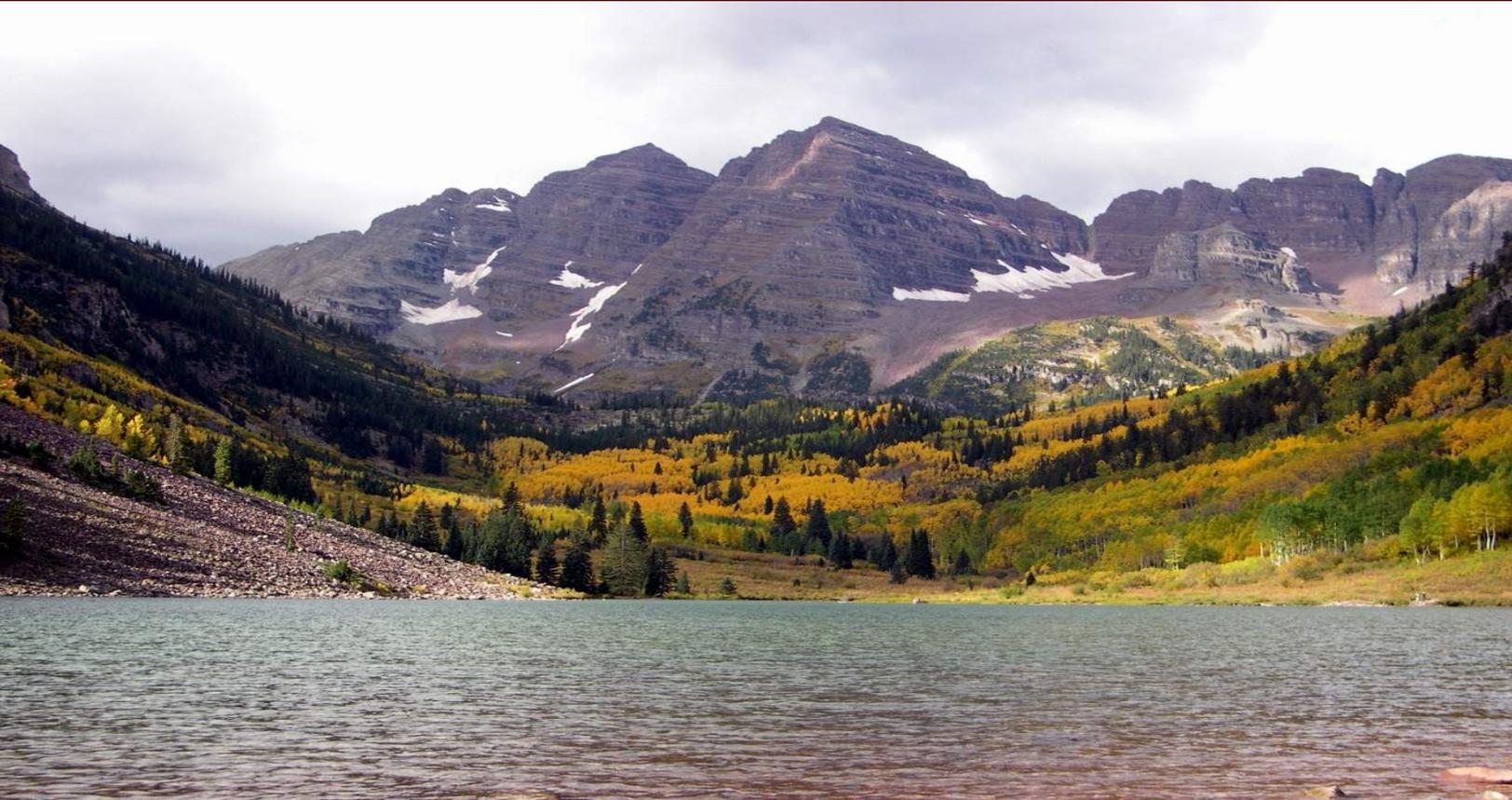
Most state alliances intend to spend their second year finalizing the state action plans and beginning to carry out activities called for in the plans. Alliances seem to be focused on reaching low income populations and educating providers more than on advocacy for policy change among state legislatures and agency decision-makers.

At the second grantee meeting in February 2011, the PFP staff and evaluator were most impressed by the enthusiasm of these alliances as they headed into Year 02. Despite the variety of challenges and the chaotic health care environment, the commitment of alliance staff is impressive and inspiring. They shared suggestions for success and compared notes on strategies that could work across states. The alliances are clearly focused on their future goals and on their strengths, rather than on bemoaning setbacks and funding problems. All of this bodes well for a productive second year for these projects.

Caroline H. Sparks, Ph.D.  
ActionToQuit Project Evaluator  
School of Public Health & Health Services  
The George Washington University

*Case Study Focus:*

# **COLORADO**



*Cessation Coverage and Treatment for  
Colorado's Uninsured*

## OVERVIEW

Founded in 1963, the Colorado Tobacco Education and Prevention Alliance (CTEPA) is the oldest existing statewide tobacco control coalition in the United States. CTEPA was originally created by the American Heart Association, the American Lung Association of Colorado and the American Cancer Society, but has since grown to encompass dozens more member organizations.

The last two years in Colorado have seen opportunities and challenges to offering cessation services. CTEPA was one of the founding members of the state's Tobacco Cessation Sustainability Partnership (TCSP). TCSP has worked with the commercial plans on their cessation benefit and been monitoring a year-old state law requiring group insured policies to offer a cessation benefit based on the USPSTF A and B recommendations. More than year ago, Colorado's Medicaid program dramatically improved its benefit, providing two 90-day quit attempts per year with access to all FDA approved medications. Budget cuts have reduced the ability of the state's Quitline to promote its free services but a partnership with health plans, facilitated by TCSP, has allowed the Quitline to continue providing free services. However, a reduced promotional budget has resulted in large scale reductions. There have been group and coalition work with the state's public and private plans but no work addressing the state's uninsured tobacco users (as outlined in the chart below).

### Colorado's work toward comprehensive coverage for all tobacco users:

| <i>Insurance Status</i> | <i>Coverage or entity leading coverage effort</i>   |
|-------------------------|---|
| Insured                 | Colorado's TCSP is completing work of implementation of A & B guidelines                  |
| Public Option           | Medicaid provided recent coverage improvement but counseling provision needs improvement. |
| Uninsured               | CTEPA's current ACTION plan addresses this population                                     |

CTEPA proposed to conduct a series of meetings and key informant interviews followed by a statewide summit to develop a strategic plan to provide comprehensive cessation treatment for, and effective utilization by, Colorado's uninsured tobacco users and a communications plan to increase effective utilization. The plan would outline the comprehensive coverage needs for the uninsured and its subpopulations, describe the barriers and solutions for comprehensive care and effective utilization, and provide infrastructure/policies/costs involved in implementing the plan.

### Objectives included:

- Develop a baseline report assessing current coverage and gaps in tobacco cessation resources for Colorado's uninsured population.
- Recruit at least 75 stakeholders for participation in key informant interviews or roundtables and a state summit.
- Create a presentation for the state summit to:

- Outline comprehensive tobacco cessation coverage, using best and promising practices, for uninsured and its subpopulations such as tobacco users utilizing mental health and/or substance abuse treatment services.
- Examine barriers and solutions to comprehensive coverage and utilization.
- Have 75% of stakeholders demonstrate increased knowledge of existing cessation resources or best and promising practices at the conclusion of the project.
- Develop a strategic plan for comprehensive care and utilization for Colorado's uninsured tobacco users, including infrastructure, costs, policies, partnerships needed.

## **ENVIRONMENTAL SCAN**

Colorado's tobacco control program, administered by the Colorado Department of Public Health and Environment (CDPHE), has historically provided funding for different programs and services to help reach Colorado's disparately effected populations. Past program funding involved outreach to medical professionals including health care provider practices serving the uninsured and low income populations. This outreach included training on the cessation and secondhand smoke exposure reduction clinical guideline, in addition to prevention and cessation education programs targeting disparate populations. CDPHE also offered low income population planning grants which concluded in May 2010.

The Colorado Quitline provides coverage to all callers regardless of insurance status. According to CDPHE, approximately 34% of Quitline callers do not have insurance. The Quitline offers over the counter (OTC) Nicotine Replacement Therapy (NRT) and serves just a small percentage of Colorado's 640,000 tobacco users. Additional interventions may be needed for the state's disparate populations such those with mental illness or addictions to other drugs. For additional information on Colorado's uninsured population, please see Attachment 1.

Over the past three years, Colorado has implemented a groundbreaking public-private partnership that has resulted in local health plans paying the cost for their fully insured members to use the state Quitline. Because of this support, current funding in Colorado will allow for:

1. Continued work in improving the tobacco cessation benefit and utilization of the cessation benefit for those privately insured and covered by Medicaid.
2. Maintenance of Quitline coverage for uninsured Coloradoans at the State's expense.

However, other than this ActionToQuit Grant in Colorado, there has been no explicit collaborative activity to address either the continuation of Quitline coverage for Colorado's uninsured population or provision of any other services.

Colorado's uninsured population is estimated to include more than 800,000 with an adult tobacco use rate of 32%, almost twice the state average of 18%. The current arrangement with private health plans is likely to change over the next several months and years due to the new health plan requirements included in the Affordable Care Act (ACA). Many of the currently uninsured will ultimately have access to coverage as the nation and Colorado moves to implement the ACA. However, preliminary estimates indicate that approximately 25%, or 200,000 Coloradoans will continue to be uninsured post-ACA implementation. Thus, CTEPA's focus on uninsured citizens is critical to maintain access to the Quitline and other relevant cessation services for this high tobacco using segment of the population.

## EVALUATION OF THE PROGRAM

As described in Colorado's logic model, CTEPA's grant inputs included CTEPA as the lead agency, its Executive Director, Bob Doyle, as the project lead, and consultants Michele Patarino and Claire Brockbank as staff. Bob, Michele, and Claire have long histories in Colorado tobacco control and they were able to leverage existing relationships to bring 32 representatives from health care providers serving the uninsured, health plans, cessation experts, media, healthcare access focused organizations, and business community/chambers of commerce to the stakeholder group. For recruitment, CTEPA used its involvement with the state's Tobacco Cessation Sustainability Partnership, Latino Tobacco Prevention and Education Network, Colorado Black Health Collaborative, and the Tobacco Disparities Advisory Committee to make contact with eventual Summit attendees.

The focus was to have an alliance that was representative of the different stakeholders when it comes to cessation for the uninsured. The stakeholders included those representing the community clinics, persons working with disparately impacted populations, pharmaceutical companies, Medicaid, chamber members, and public health professionals.

Prior to the October 21 summit, an assessment of resources including current coverage and gaps in tobacco cessation resources for Colorado's uninsured population was developed (see Attachment 1). E-mails were sent to stakeholders on August 20, August 31, September 10 and October 6 prior to the summit, and included a request for participants to fill out the online survey. Webinars were held on September 22 and October 8, 2010, educating stakeholders on healthcare reform and tobacco cessation basics.

At the Summit, presentations outlined the current state of cessation services for all populations (Medicaid, private, and uninsured) and a picture of how cessation resources and benefits will change for all populations as we move toward 2014. The other focus area was a presentation and discussion on how to drive effective demand among our low income tobacco users.

A list of questions and recommendations has been developed from the Summit to help guide a final webinar and meeting to complete the plan. Since the summit, meetings have been conducted with representatives from clinics, hospitals, and health care access, and marketing representatives on the summit discussion and the evolving world of health care access. A webinar and follow up meeting are planned for February and March.

In addition, the Colorado team received a survey report from Dr. Caroline Sparks, the project evaluator. Key points extracted from the survey for use in the Action Plan include:

- High support for comprehensive tobacco cessation services for people who smoke (24 of 29) but also high belief that reluctance of insurers and employers to cover cessation services is a major barrier.



*Bob Doyle, Executive Director, Colorado Tobacco Education Prevention Alliance*

- All respondents rated raising smokers' awareness of tobacco cessation services as the highest priority. This demonstrates a need for heavy investment in communication and outreach.
- Respondents indicated a lack of confidence in their ability to advocate for policy changes with state legislators. This warrants some further analysis of the survey results.

## **CHALLENGES**

Colorado's summit came at a challenging time for tobacco control professionals in the state given the recent budget reductions. Many funded agencies were no longer providing programs and no longer had dedicated staff (for example, the Colorado Clinical Guidelines Collaborative, which identified and offered education to health care providers for nearly a decade). For agencies that were still funded, they were clearly doing "more with less." Because of CTEPA's history of working with the state tobacco prevention organizations, especially those working with disparate populations, we were able to engage the partners in this important project.

The other challenge was the ongoing uncertainty surrounding health care reform. Specifically, within the business and health plan community, there was some reluctance about looking at a cessation benefit because there were so many larger moving parts to health care reform and an uncertainty about how health care reform would impact the various players. The other challenge was that clinics serving the uninsured were stretched thin with staffing and increased demand due to the economy. The November election had several ballot measures that required attention from many health care access organizations. Two ballot measures would have caused a dramatic reduction in the state budgets and a third was trying to have Colorado opt out of health care reform. Thankfully, none of the measures passed. In each case, it required both before and after the summit engaging persons individually rather than in group or roundtable settings as originally planned.

Finally, the Tobacco Cessation Sustainability Partnership (TCSP), which developed the public-private partnership to extend Quitline sustainability (see Section B), had taken a good bit of time and resources from many tobacco control advocates, who were receptive to the summit, but felt like they had already given of their time and talents. To address this, TCSP was represented during the planning process for the summit as well as the summit itself and provided detailed updates to all members of TCSP.

The ongoing challenge has been to locate marketing studies/experts outside of health on how to successfully target low income populations. I have met with various experts to help develop a plan to locate and comb any data that may be available.

## **LESSONS LEARNED**

Health care reform brings opportunities and challenges. There is interest in work like ours because public health professionals need assistance with navigating this new era. Our work can help them understand the possible positive and negative impacts reform will have on cessation and other issues. The complications of health care reform, including the Accountable Care Act, Meaningful Use, FDA warning labels, and other topics were important for stakeholders to understand in developing Colorado's action plan. The need to track reform, interpret its implications at the state level, and translate this into lay language added complexity to and demanded unanticipated resources from the project. While educating stakeholders on these issues was time-consuming, it contributed to our ultimate success.

The negative impact of health care reform is the uncertainty or ongoing evolution of how reform will affect businesses and health plans. This creates a very cautious environment where few are willing to commit to, or

consider, any new business practices.

The ongoing budget cuts have left most organizations in public health and health care stretched on staffing and available time. This has required more time needed to reach each individual.

Another positive aspect was the very specific focus on the uninsured which gave the team a clear path, making it easy to select who should be involved in the summit. The other positive aspect was being connected to the other cessation projects/coalitions in the state to avoid duplication and to complement each other's work.

## **LOOK TO THE FUTURE**

This project provided the foundation for the development of a plan and coalition to provide the best resources in the country for all of Colorado's tobacco users. In 2011, the goal is to finalize a plan that outlines how to provide the "gold standard" of cessation resources, including a comprehensive communications plan, for tobacco users in three categories – uninsured, public, and private plans. By summer of 2011, we will have expanded the coalition to include those involved in public and private plans. By early winter of 2011, the goal is to have an easy to understand strategic plan for the public, media, and elected officials on what Colorado needs to do to become the best in the nation and outlining the costs associated with the new plan.

For our evaluation, we want to show a greater awareness of the policies needed to support the strategic plan and a greater willingness to advocate for the action steps outlined in the strategic plan.

*Case Study Focus:*

# **FLORIDA**



*Using Social Media at a State Tobacco Cessation  
Summit to Create an Action Plan*

## OVERVIEW

The Florida Tobacco Cessation Alliance, led by the American Lung Association in Florida, work together to raise awareness that tobacco addiction is a chronic, relapsing medical condition, not just a habit or personal choice, and to advocate for the adoption of comprehensive cessation resources for all tobacco users statewide. Comprised of partner organizations including the Florida Department of Health, Florida Academy of Family Physicians, Florida Osteopathic Medical Association, Tobacco Research and Intervention Program at H. Lee Moffitt Cancer Center, the American Cancer Society, the American Heart Association, the March of Dimes Foundation, the Florida Association of Health Plans, the Partnership for Prevention, Campaign for Tobacco-Free Kids and the Florida Area Health Education Centers (AHEC) Network, the Florida Tobacco Cessation Alliance worked together to implement an ActionToQuit grant project entitled “Using Social Media at a State Tobacco Cessation Summit to Create an Action Plan.”

1. During the first year, the Florida Tobacco Cessation Alliance established and accomplished aggressive goals. They planned and conducted a Tobacco Cessation Summit on October 14, 2010. The Summit audience included large employers (both state and municipal), health providers, health care insurers, policy leaders, public health professionals and others. Our goal was to have 100 people actively participating in the summit in person with an additional 100 participating via video conferencing. We were successful in recruiting 65 people to attend in person at the Sanford-Burnham Medical Research Institute. We were very pleased with our statewide outreach, broadcasting the program live to 27 different locations around the state with more than 100 people participating remotely.
2. Through the Summit, the Alliance educated participants about the health and economic benefits of 1) treating nicotine addiction as a chronic relapsing disease and 2) providing comprehensive smoking cessation treatment consistent with the U.S. Department of Health and Human Services’ Public Health Service Clinical Practice Guidelines on Treating Tobacco Use and Dependence. In addition to the summit participants, the Alliance has been successful in educating the general public and decision makers through our earned media campaign and individual meetings.
3. Using the consensus group action steps created at the summit, we developed an action plan for the state of Florida with measurable, low or no-cost strategies that participants or any employer can implement within their own organizations.
4. We provided follow up with each participant for additional input. We will continue to communicate with them to encourage implementation of the action plan and to provide technical assistance in moving the issue forward within each of the target audiences.

## ENVIRONMENTAL SCAN

Representing 17.1 percent of the population, adult smokers in Florida cost the state an estimated \$12.8 billion in direct and indirect healthcare expenditures. During the past 15 years, the American Lung Association has been instrumental in Florida’s adoption of strong tobacco control policies including: the recent \$1 surcharge to the tobacco excise tax; a solid workplace smoking ban; and a significantly funded tobacco control and prevention program.

As the result of an amendment to the Florida Constitution, since 2006, Florida’s legislature is mandated to provide 15 percent of the tobacco settlement payments to fund a comprehensive, statewide tobacco education and prevention program. The program is mandated to be consistent with the CDC's Best Practices for Comprehensive Tobacco Control Programs. Currently managed by the Florida Department of Health, the

program provides funding to communities for local tobacco policy change, youth activities through SWAT (Students Working Against Tobacco), Florida's quitline, local smoking cessation services and education of medical practitioners (through the AHEC Network), a multi-media campaign as well as program evaluation and surveillance. Since funding began in 2007, the program has seen remarkable results. There is an estimated 500,000 fewer adult smokers, the youth smoking rates have dropped by 9 percent, and personal health care expenses have declined by approximately \$1 billion annually.

Florida's tobacco prevention program provides significant resources to help people quit smoking. Its quitline served more than 44,000 people last year by providing multiple proactive counseling sessions, with 30,500 receiving nicotine replacement therapy. The Florida Quitline has an impressive quit rate of with 31.6 percent of the people not smoking for 30 days prior to the seven month follow-up survey. In addition, the AHEC Network provides in-person counsel both in group and individual sessions throughout the state. These programs are supported and promoted by a well-funded, statewide multimedia campaign.

However, Florida does little to provide smoking cessation resources to its state workers and Medicaid populations. According to the *American Lung Association's State of Tobacco Control 2010* report, Florida received an "F" in cessation coverage, reflecting a failure to reduce barriers and provide the treatment options recommended by the Clinical Practice Guideline on Treating Tobacco Use and Dependence. The American Lung Association in Florida and its partners were successful in obtaining some benefit coverage for tobacco cessation medications for state employees, but more progress needs to be made.

## **EVALUATION OF THE PROGRAM**

The Florida Tobacco Cessation Alliance was able to utilize the anticipated inputs outlined in the attached Project Logic Model to achieve all planned activities. We were also fortunate to have additional partners join the Alliance, such as the Florida Association of Health Plans and the Campaign for Tobacco-Free Kids, as well as the incorporation of new resources, such as the innovative A/V at a superior event site and electronic polling equipment. We were very fortunate to have the Florida Department of Health allow the use of their statewide video conferencing system as an in-kind contribution. The time required to ensure the compatibility of the equipment with the site's system was significant. Fortunately, the American Lung Association in Florida was able to obtain additional funding to help defray the cost associated with this project .

The Florida Tobacco Cessation Alliance is comprised of a network of groups determined to improve the health of our state. One to two representatives from each organization assisted the American Lung Association in planning the Tobacco Cessation Summit, including participating in all planning calls and meetings, as well as providing support on analysis and refinement of the Summit recommendations used to form the attached Action Plan.

Planning activities for the Summit consisted of monthly and bi-monthly meetings with our Alliance members in the time leading up to the Summit, as well as weekly interaction on both the phone and through email. We hired a Summit and Action Plan consultant, Jennie Hefelfinger with Hefelfinger Consulting, LLC, who worked with us to prepare the meeting agenda, brief the speakers, keep the day running smoothly and on-time, and analyze and structure the data and recommendations from the Summit and the Alliance members into a cohesive and thorough action plan, as attached. Following the Summit, Jennie led the Alliance in smaller work groups, segmented by the four key audiences outlined at the Summit, who worked to refine the recommendations and action steps that made up our finalized action plan.'

The Alliance reached out to well more than the 300 potential participants proposed for attendance. Information about the summit was distributed through the Florida Association of Health Plans, the Florida Hospital

Association, the Florida League of Cities, the Florida AHEC Network, the Florida Academy of Family Physicians, the Florida Association of Counties, the 67 county-level tobacco partnerships, the Florida Society of Human Resource Managers, as well as personal contacts with businesses and large employers. Prior to the Summit, a website was developed to provide information about the summit and let visitors register online. This allowed the Alliance to capture email addresses in order to encourage participation in a pre-Summit survey. The survey was completed by most of the attending participants. In the end, the Tobacco Cessation Summit was attended by 65 people in person at the Sanford-Burnham Medical Research Institute and more than 100 people in 27 County Health Departments across the state. A robust agenda included a morning filled with educational information which laid a foundation for the afternoon's group work. Participants learned about the burden of tobacco use, the physiology of nicotine addiction and treatment, the economic impact of tobacco use and the return on investment when comprehensive treatment is provided. Presentations were given by Thomas Brandon, PhD with Moffitt Cancer Center, Jennifer Singleterry with the American Lung



**Brenda Olsen** (right), Chief Operating Officer and  
**Amanda Fliger** (left), Director of Communications,  
*American Lung Association in Florida*

Association and Diane Canova with the Partnership for Prevention. During the presentations, remote locations were encouraged to “tweet” their questions using a specific hashtag, and we received additional inquiries from remote sites via email.

The latter part of the day involved group work, where clusters of attendees (each assigned one of our key target audiences) answered a series of questions and provided 5-7 recommendations. These answers and suggestions were captured by a recorder electronically and posted to a Grouply site, which allowed for remote locations to follow along with the dialogue and for those in-person to derive some inspiration from other groups. This technology was also key in helping the event facilitator, Jennifer Hefelfinger, quickly summarize the group work and develop questions to ask during the reporting portion of the day.

During the presentations and after, we conducted live, electronic polling to gauge the audience's knowledge and establish priorities for developing the action plan. The audience found this technology engaging, and it provided some surprising insights. We also posted the

PowerPoint presentations and various resources that were shared on the flash drives given at the Summit on the website.

Additionally, we drafted an op-ed profiling the issue and the Summit, which was published under various Alliance members names in the Daytona Beach News-Journal, Orlando Sentinel and Florida Times-Union (estimated print impressions: 923,547). We also secured coverage of the Summit in publications such as Health News Florida, Capital News Service; and WFTV-TV (Channel 9, Orlando) covered the Summit and conducted on-site interviews.

In the months following the Summit, the Alliance and our consultant worked to develop recommendations in each of the four main target audiences reflected in the plan. Utilizing the notes retrieved from Grouply and from the live polling, recommendations were reflective of those who participated in the Summit.

## **CHALLENGES**

Throughout the process of building the Florida Tobacco Cessation Alliance and executing the summit, a major challenge was engaging and recruiting large, private businesses. Finding the appropriate person to contact, generating the messages that would resonate best for the audience and getting the Alliance's "foot in the door" all proved to be a challenge. We continue to struggle with engaging this audience, but we are working to ensure that we have business-friendly messages and resources on our website and in our materials. We are actively seeking funding to develop a more functional website that will offer businesses more resources.

Another challenge which occurred throughout the planning and executing of the summit was adapting to use new technologies and resources. An original intention, using Facebook to garner input from interested parties not present at the event, did not happen due to restrictions by the site. Fortunately, the availability of other social networking sites that better fit the needs of the summit allowed us to successfully incorporate the use of [www.groupy.com](http://www.groupy.com) to achieve our goals.

We continue to struggle with improving coverage for Medicaid recipients and state employees. In Florida, government departments that manage these programs are held under extreme scrutiny by the public and the legislature. Given the major budget deficit facing the state, any additional services, regardless of the return on investment, have little chance of being debated and much less chance of being adopted.

## **LESSONS LEARNED**

We were pleased with not only the immediate outcomes of the summit (number of attendees, use of social media, etc.) but with the momentum and excitement the event created for this issue. This excitement ultimately translated into logical and cohesive recommendations to create an overall Action Plan for the state of Florida.

Another success was the media attention drawn to not only our event, but to the topic of smoking cessation statewide. This, coupled with the use of new technologies at the summit, created a buzz at the event and about the Alliance. There was an overestimation of the amount of audience that are comfortable and familiar with using certain social media technologies, so it is important to keep this in mind with planning future events.

We found hiring a consultant invaluable to the process of executing the summit and creating the action plan. Jennie Hefelfinger was essential in steering the summit planning in a way that kept our objectives and outputs front-of-mind and led the day's activities with grace and efficiency. After the summit, Jennie expertly assisted the Alliance in analyzing the raw data and facilitated the appropriate discussions and strategy sessions to create the thoughtful recommendations for each of our key audience segments.

An interesting lesson is that the general public does not understand the term "cessation". Our Alliance has made a strategic decision to move away from using it. We have determined that the use of "tobacco dependency treatment" more accurately reflects the outcome for which we are striving. We also believe that using this phrase generates a more clinical approach or feel, rather than just trying to get people to kick a nasty habit.

## **LOOK TO THE FUTURE**

The Alliance is actively recruiting other organizations and entities working on the issue of tobacco dependency to expand the reach of the recommendations and ensure access to comprehensive tobacco dependency treatment. Partnering and collaborating with local tobacco prevention partnerships and other stakeholders is critical in promoting and implementing these recommendations.

Additionally, the Alliance will begin to implement the important recommendations found in the State Action Plan and reach out to summit participants and other interested parties with resources and information. An assessment meeting will be held to determine what resources each Alliance member can contribute and what current activities are being performed in each organization that address Action Plan recommendations. Amplified communication with stakeholders, including the use of social media tools, the Alliance website and other methods will ensure they see the progress being made on the issue and have the opportunity to contribute and assist in moving the plan forward.

Utilizing the collective experience and expertise of our Alliance members, we hope the long term impact of these efforts will result in more private employers offering comprehensive tobacco dependency treatments through their insurance plans and that state workers and Medicaid workers will also be provided with comprehensive tobacco treatments. Breaking nicotine's deadly addiction is a daunting task—sometimes requiring multiple quit attempts and a variety of treatment methods. The Florida Tobacco Cessation Alliance is dedicated to ensuring that every Floridian who wishes to quit using tobacco has the resources to do so.



*Case Study Focus:*

# **NEVADA**



*Increasing Tobacco Cessation Access for All Nevadans*

## OVERVIEW

The American Lung Association in Nevada (ALAN) hosted a statewide summit: Increasing Cessation Access for All Nevadans (ICAAN) in the fall of 2010. ALAN applied the feedback from the summit and is developing it into a State Plan to improve cessation access for all Nevadans. ALAN is continuing to work closely with the Nevada Tobacco Prevention Coalition (NTPC) as well as the ICAAN Executive Committee to coordinate key stakeholders from the community and nonprofits to expand cessation coverage.

ALAN is also continuing our partnership with organizations such as Nevada Tobacco Prevention Coalition, Nevada Tobacco Users Helpline, Renown Health, American Cancer Society, Nevada Cancer Institute, and American Heart Association.

ALANs goals during our first year were to: 1) Improve cessation access among disparately impacted populations and 2) Engage healthcare providers in systems change that promotes routine tobacco treatment. Furthermore, 75% of participants attending the ICAAN Summit will have increased their understanding of the issue of improving Nevadans' access to tobacco cessation. From the summit, ALAN would develop an ICAAN State Plan which integrates specific strategies to improve access for disparately impacted populations.

ALAN plans to have representation from:

- Nonprofits
- Insurance providers
- Healthcare providers and systems
- Businesses and employers
- Unions and employee advocacy groups
- Policy makers
- Organizations reaching minority, underserved, and disparately affected groups including low-income, unemployed and the GLBT community.

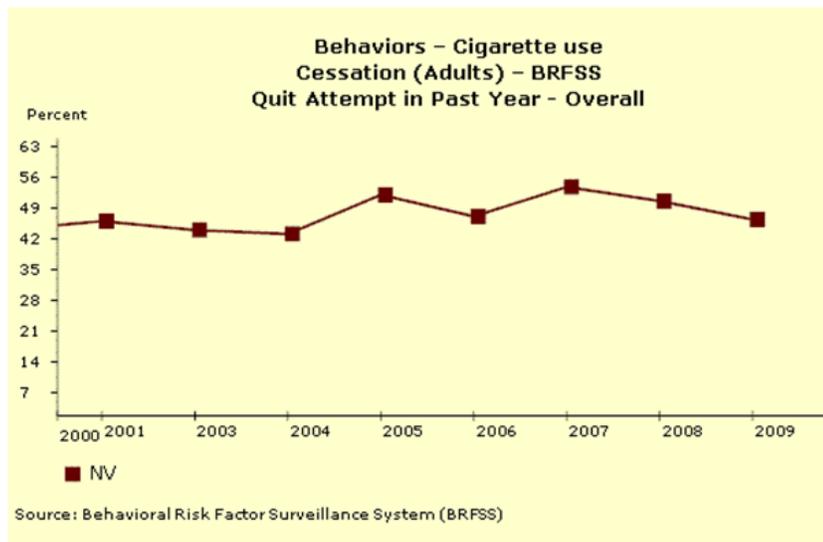
ALAN has a long term goal of decreasing morbidity and mortality from use of tobacco products.

The objectives of the ICAAN project were: 1) at least 50 individuals representing multiple sectors will attend the ICAAN Summit; 2) 75% of participants attending the ICAAN Summit will have increased their understanding of the issue of improving Nevadans' access to tobacco cessation; 3) 75% of participants at the ICAAN Summit will commit to engaging in further action toward increasing Nevadans access to tobacco cessation (i.e., participating in a workgroup, improving cessation practices at their company/hospital, promotion of the State Plan, etc.); 4) an ICAAN State Plan which integrates specific strategies to improve access for disparately impacted population will be created; 5) 250+ healthcare providers will attend ICAAN in Healthcare Systems presentation/dialogue; ; 6) 75% of healthcare providers attending the ICAAN will be in Healthcare ; and 7) systems presentation and dialogue will have increased participants' understanding of the healthcare system changes recommended by the PHS Guideline.

Currently Nevada ranks above the national average for smoking and other tobacco use as evidenced by the most recent BRFSS data. The prevalence of smoking in Nevada has ranged from 26.4% in 1995 (the first year of Nevada participating in the BRFSS data collection), to a high of 31.5% in 1999, down to 22% (over 428,000 people) and this is the issue our alliance addressed.

## ENVIRONMENTAL SCAN

The percent of smokers calling a quitline has a National average of 2.8%. In Nevada 1.4% of current smokers called the statewide quitline, ranking 41st in the union. According to the most recent data in 2006 and 2007, in Nevada, 1.4% of smokers called their quitline (TUS CPS, 2006, 2007). Nevada, however, is one of six states to cover all treatments that Medicaid recipients need to quit tobacco (nicotine replacement therapy, prescription medication, and counseling). There is one caveat, which is that counseling services (both group and individual) are only covered under certain circumstances of policy coverage. Also, Medicare and Medicaid dollars cannot be spent to support quitlines, so neither program covers phone counseling (MMWR 2009). When examining the data for quit attempts, 50.3% of Nevada smokers attempted to quit in 2005, 45.4% in 2006, 52.1% in 2007, 52.1% in 2007, 48.9% in 2008, and 44.7% in 2009, which is shown in the graph below.



Freedom From Smoking (FFS) is an online program offered by the American Lung Association. This program is designed for adults who want to quit smoking. Participants gain access to online support and guides through the FFS website to assist them in quitting.

Medicaid cessation services and Freedom from Smoking (FFS) online are fully supported but not well known. Hospital cessation programs are well promoted and utilized. Through ICAAN action steps we hope to close the gap in service and coverage by promoting the Nevada Tobacco Users Helpline (NTUH) further, increasing availability of cessation services to the public, healthcare providers in Nevada. We also plan on working to increase funding for tobacco control programs for youth and adults. Not-On-Tobacco (NOT) is a tobacco cessation program for teens, currently implemented in only two high schools in northern Nevada. From the Summit we hope to implement more programs each year with a focus on rural Nevada.

- **Insurance Coverage:** Nevada received a “C” from the ALA’s 2010 State of Tobacco Control Report Card for cessation coverage.
- **Quitline:** Unclear how the NTUH is effectively and thoroughly reaching populations disparately impacted by tobacco use. Data gathering and assessment are needed.
- **Healthcare Systems:** Barriers to cessation support need to be identified for all healthcare systems.

## EVALUATION OF THE PROGRAM

Our planned activities were a big component of our actual activities at the Summit. Recruiting and organizing a state-wide alliance for increased access to tobacco cessation service was accomplished by developing a plan that institutionalizes treatment of tobacco within health care systems and provides cessation resources to tobacco users.

We are in the process of sustaining implementation of youth cessation programs throughout Nevada by using university student volunteers as facilitators and training facilitators within communities. Implementation of programs in rural Nevada is also in progress for this year and the second year. Goals: to increase the number of Not-On-Tobacco (NOT) programs in Nevada by 50% for short impact with a long term impact goal of increasing the number of teens that attempt cessation by 25%.

ALAN plans to close the gaps in coverage for our citizens of Nevada by promoting the Quit Line through ALAN and NTPC websites. *Goals:* 10% increase in the number of calls from rural Nevada; 10% increase in calls in urban northern Nevada.

Our planned activities included the work groups continuing to meet for 60 days after the Summit. Work groups have extended and continued to meet for another 120 days. The work of drafting a strategic plan and submitting it to ICAAN Executive Committee has been completed and is waiting on the group approval and recommendations. Increasing price (and/or) tax with the participation of ALAN and NTPC is in the progress; their work group input has been crucial. Work groups have finished their timeline and have begun to execute their action steps.

ALAN will work closely with the Nevada Tobacco Prevention Coalition (NTPC) (a statewide coalition of more than 45 concerned Nevadans, organizations and public health officials) to engage representatives from business, employer, healthcare, insurance, employee, and nonprofit groups in a dialogue about expanding cessation coverage for all Nevadans, including those disproportionately impacted by tobacco use.

Another resource that we had is the Nevada Tobacco Users' Helpline. NTUH is a nicotine dependence treatment center offering telephone-based tobacco treatment.

The state-wide alliance was formed by bringing together key players in Nevada tobacco education and control to be on our Executive Committee. Our committee meets monthly by conference call. They are provided with regular email updates and approve all documents and procedures regarding the state plan. Once the plan has been completed and approved, the Executive Committee will work together to disseminate the plan throughout the state. With their help this will ensure the plan is distributed to stakeholders, published online and issued in a press release. They will also help to create promotional materials for use by partners. Our committee consists of an exceptional group of leaders with a passion for tobacco cessation.

One challenge was finding a smoke free, suitable location in the Reno area. A great percentage of banquet rooms and conference centers are located inside casinos which are exempt from the Nevada Clean Indoor Air Act and allow smoking. Once we found our location, The Grove, which is entirely smoke free, we were able to begin the planning process. We started recruiting members for the Executive Committee, guest speakers and attendees. Our Executive Committee consists of the key players in tobacco and public health; we used their perspectives to help make our process smoother. While we recruited invitees, we made sure to extend our invite to other key players who are affected by smoking: fire marshals, key businesses, unions, faith based groups, insurance companies, and representatives from workman's compensation. We were then able to secure our speakers, their PowerPoints and lectures, and our panel. Next was media coverage; News Chanel 2, a local CBS affiliate, came to our event and did live coverage of the Summit. After all of the presenters and

panelists had finished, the facilitator asked for suggestions of additional possible work groups to the list. All participants would be asked to select three work groups they thought would be most important. Attendees dispersed into work groups to develop a timeline and action steps for their group and then presented their ideas to the gathering.

Following the ICAAN Summit, work groups were provided with a contact list and worksheets to schedule a follow up meeting. Work on the state plan began the week following the Summit. Each work group researched data, assessed needs, and prioritized actions. With each group focusing on their own action steps and relaying accomplishments back to the state plan writer, the process started smoothly. Inside the plan you will see a list of priorities for all work groups and some barriers that have affected the implementation of the action steps. The work groups continue to meet monthly to discuss progress, goals, and future steps. Progress has been made and added into the state action plan as an update.

Seventy-five participants completed a pre-summit survey. Based on the survey, several potential work groups were later developed.

On October 21, 2010, 66 participants from the top tobacco alliances in Nevada came together to discuss tobacco cessation and planned to increase cessation access in a day long Summit. Facilitated by Jennifer Hadayia, Washoe County Health District, Public Health Program Manager, the Summit began with introductions followed by key speakers presenting their current policies, challenges, and future opportunities. Tracey Green, MD, Health Officer, State of Nevada, Daniel M. Cook, PhD, University of Nevada, Reno, School of Public Health, Nadine Simons, MS, RN, CAPT, U.S. Dept Health & Human Services, were among the morning presenters. Panel presentations were followed by Q&A. Each Summit attendee was given a program binder with each speaker's PowerPoint, smoking cessation resources and a contact list of all attendees. Following the presenters and panelists, the facilitator added additional possible work groups to the list.

Before break, everyone was asked to vote for their top three priority group work areas. All participants then selected the three work groups they thought were most important. Based on the most popular work groups, the following work groups were established:

- Price
- Closing the gaps in coverage
- Smoke Free Spaces/Places
- Youth and Adult Cessation Programs
- Increasing Public Awareness

Immediately following break, work groups met based on expertise areas to begin development of state-wide plan; work groups evaluated needs, ranked policy options and formed action steps (developing a plan of action).

Work groups reported their results and discussed possible further action steps. We documented work group contacts for continued communication. Discussion began on the next steps for the group as a whole and a conclusion followed. Primarily through conference calls, the workgroups will further develop the action steps proposed at the Summit as well as fill in any gaps needed to complete the State Plan.

ICAAN participants ranked the priority in order of: 1) increasing smoker's awareness of tobacco cessation services; 2) ensuring resources are available to tailor programs to reach specific populations; 3) ensuring that all health systems and health providers talk with users about cessation medications and therapies. The highest priorities targeted patients and providers. Lesser priorities for the participants included policy change and other alliance work.

Most of the participants from the ICAAN Summit reported being “likely” to be an advocate for tobacco cessation resources/services. These participants rated themselves as moderately high in self-efficacy. Most participants are moderately confident that the Nevada state alliance is capable of taking action. ICAAN participants are very aware of the tobacco population. Overall, the ICAAN participants are aware of the barriers for improved service and feel as if they can take action as advocates.

The exciting action taken by Dan Cook, UNR Professor, and his students is perfect example of the efforts taken as a direct result of the Summit. The Great American Smoke Out was held on November 18, 2010 where students from the addiction class at the University of Nevada set up a booth/table on campus. They had 25 volunteers, counted 54 completed "surveys" (questions about Hookah safety). They reported having another 50 more that did not complete the survey. The audience was mostly traditional college age students; however a tour group of high-school students spent considerable time at the table as well. They had other messaging and signage around campus reaching unknown others.

## **CHALLENGES**

As of July 1, 2010, Nevada’s legislature and governor had channeled all the money allocated for tobacco education, cessation, and control (MSA dollars) throughout Nevada into the general fund in an attempt to alleviate the state budget shortfall. This left the American Lung Association tobacco programs, the Nevada Tobacco Prevention Coalition and all our tobacco partners throughout the state having to dramatically reduce staff and working to find other funding sources to sustain tobacco control programs. This has diminished tobacco education, cessation, and control staff and programs everywhere in Nevada. With the loss of funding, most agencies had to reevaluate how to sustain tobacco control efforts. The American Lung Association in Nevada and their partners in tobacco control contacted and rallied all our allies in tobacco programs and invited them to attend the ICAAN Summit while also reaching out to new partners in business, insurance, health care, and faith based communities. The American Lung Association and state wide partners held the ICAAN Summit and developed a strategic plan to continue to address cessation issues and programs in our state. Out of that gathering came a renewed energy and commitment to moving forward on behalf of tobacco control, education, cessation issues and programs. As one ICAAN attendee remarked, “We were down but we weren’t out.”

We were able to overcome these challenges because of our strong partnerships and successful past history in Nevada. The American Lung Association and their partners were excited to develop a strategic plan going forward and extended ICAAN invitations to a host of nontraditional communities, including NAACP, Hispanic services, firefighters, LGBT, Chambers of Commerce, workman’s comp organizations, private insurers, Employee Assistance Programs, Housing Authorities, Juvenile Justice, Law Enforcement, Health Care, Tribal entities, treatment centers, banking, and campus organizations. Having Anthem/Wellpoint, Inc. on our panel sharing their interest and expertise on increasing cessation provided an indirect pipeline to the employees of the larger insurers in Nevada.

The invitation heightened cessation awareness throughout Nevada, even in the disparate areas. Faces new to tobacco in Nevada were at the table during the ICAAN Summit including faith-based, Hispanic Chamber of Commerce, private insurers, tribal centers, low-cost clinics, and health care campuses. Many attendees reported being especially impressed by the representative from Saint Mary’s Regional Medical Center’s presentation on “Lessons Learned from Going Tobacco Free”. All hospitals in Reno went tobacco free Jan 1, 2010 in a united effort to curb the impact of tobacco on patients, staff, and their campuses. The Saint Mary’s representative described the unexpected benefits of being tobacco free. Some of the benefits included fewer

fire alarms and fires. Numerous patients who were prescribed nicotine replacement therapy in the hospital continued to be smoke free upon returning home. In addition, this lightened the load of hospital security. All these “non-traditional” tobacco cessation impacts surprised even the most experienced tobacco control advocates in attendance.

## **LESSONS LEARNED**

The positive aspects of the ICAAN Summit included working together as a team to develop a plan to sustain cessation efforts in Nevada with reduced funding and partnering with new communities interested in taking part in tobacco cessation issues. As a result of the Summit, participants have a clear vision of the steps we need to improve, maintain and sustain cessation services in our state. Bringing together various businesses, organizations, and public health entities, attendees felt a renewed sense of purpose and collaboration in the tobacco community and were eager to move forward. We wished we had used more web-based dissemination of information to connect more with general public/media.

## **LOOK TO THE FUTURE**

We have revitalized connections and hope to see more funding become available to ensure increased cessation access. ALA is committed to facilitating and disseminating the state plan as intended for the next two years.

ALAN’s Vision for Year Two:

- Implement action steps in I-CAAN State Plan
- Utilize workgroups to prioritize plan activities and keep partners connected
- Collaborate with NTPC (Nevada Tobacco Prevention Coalition) to ensure mechanisms to measure impact of Plan activities are in place
- Educate policy makers about the I-CAAN Summit and Plan
- Link I-CAAN partners (esp. non-tobacco control) into advocacy networks to mobilize in support for policy change.

Implementation of the state strategic plan will ensure the work groups and stakeholders are participating as each person has their own tasks assigned to them and are following their own timeline. Within each work group is a separate timeline and task list. The dissemination of the report will happen once the ICAAN Executive Committee has read the report and is finished making approved changes.

ALAN will work with participants from each of the stakeholder groups (employers, insurers, health systems, etc.) to provide the resources and support they need to promote the Plan within their own networks

Through NTPC, concerned Nevadans, organizations and public health officials have joined together in a statewide movement to end Big Tobacco's grip on Nevada. Increasing Nevadans’ access to tobacco cessation is well-aligned with NTPC’s mission and as such, NTPC members will play an active role in activating their networks to gather support for and participation in this project. Additionally, ALAN has secured letters of commitment from Renown Health and TPEP.

ALAN intends the long term impact will be to significantly increase tobacco cessation for all Nevadans. Working with our partners statewide we will be able to go forward and achieve our goals. We hope to increase health care providers’ understanding of and support for routine tobacco treatment as well as educate the elected officials on priority areas.

**Intended impacts within the next five years:**

- Ensure that state policy makers prioritize improved access among disparately impacted populations.
- Decrease morbidity and mortality from the use of tobacco products while decreasing the number of current adult smokers by 10% .
- Increase statewide cessation attempts for the Quit Line by 15%.
- Increase the number of teens who successfully attempt cessation by 25%. This in turn will help to decrease the number of adult smokers in Nevada.
- Increase the number of smoke-free places so the culture of the state will shift to a smoke-free state.

*Case Study Focus:*

# **NEW YORK STATE**



*Securing Cessation Coverage as a Core Benefit in NYS*

## OVERVIEW

The total costs of an unhealthy workforce are growing at an unsustainable pace. Employer-sponsored health insurance plays a part in maintaining employee health. However, any approach that relies primarily on providing medical services after employees get sick is a failed strategy. Enlightened employers are looking for creative ways to help employees and their families improve their health—or to simply stay healthy.

Tobacco use is the single most preventable cause of disease, disability, and death, and is an optimal place to intervene. Each year, tobacco use claims more than 25,000 New Yorkers' lives. Most smokers want to quit but need help. 16.8% of adults in NY are smokers and, as of 2008, a greater percentage of smokers in New York made a quit attempt in the past year and had intentions to quit in the next 30 days than smokers in the rest of the United States. Annual smoking-related health care costs and lost productivity in NY total \$14.2 billion. NYS has \$8.17 billion in annual health care expenditures that are directly caused by tobacco use. Fortunately, NYS employers have the ability to offer cessation benefits and programs to reduce the costs of employee tobacco use. Because employees spend a significant portion of their waking hours on the job, employers are in a position to positively influence lifestyles. People often know what they should do; skills, motivation, and opportunity are the missing elements that keep them from making permanent, healthy changes. Employer-sponsored tobacco use cessation incentives, interventions, and programs can provide the supportive environment and structure people need to maintain healthy behaviors.

However, in seeking assistance to quit, smokers are finding numerous barriers to smoking cessation coverage in NY which impedes their chances of making a successful quit attempt. These barriers include: 1) all NYS health care plans do not fully cover comprehensive cessation services for all their members 2) NYS plans vary in coverage of effective treatment methods, co-pays, and duration of benefit 3) If benefits exist, providers, purchasers, and health care plan members are not always aware of the benefit 4) employers may be confused about cessation benefit information given there is no one defined, comprehensive standard 5) since the cessation benefit is usually a purchased plan benefit, employers may opt to not purchase services for their employees.

Many employer health benefits routinely cover preventive services. Like all other health benefit decisions, employers need to make informed decisions when considering providing tobacco use cessation benefits. The NYS Smokers' Quitline (NYSSQL) at Roswell Park Cancer Institute conducted three regional ActionToQuit Treatment Summits involving employers, health plans, and other stakeholders with the outcome of providing all stakeholders with evidence-based knowledge and a strategic plan. When realized, this plan will achieve the goal of persuading all NYS employers, regardless of size, to provide tobacco dependence treatment coverage to all employees. As a result of attending a Summit, stakeholders should be more likely to choose evidence-based employee tobacco use cessation benefits resulting in the implementation of one of the most cost-effective preventive health services that can be offered to employees.

NYSSQL and its partners conducted an inclusive strategic planning process in 2010. The new strategic plan will cover the period 2011 – 2013 and chart a path for New York to achieve its 2014 adult smoking prevalence goal of 12 percent. The new strategic plan will set the framework for a) cessation treatment coverage provided as a core benefit with NYS health plans; and b) all commercial and Medicaid insured NY smokers to have access to cessation treatment for their quit attempt. Through the development of an ActionToQuit executive committee, the use of our existing website to communicate with stakeholders, and educational outreach using Podcasts on the science of comprehensive tobacco cessation treatment, and the hosting of statewide summits in Buffalo, Albany, and near NYC, we convened at least 40% of health plans and major NYS employers combined, as well as small employer groups, to develop a NYS ActionToQuit strategic plan.

NYSSQL, NY Tobacco Control Program (NY TCP), and the American Cancer Society have working relationships with NY health plans, health plan groups, major employers, employer based groups, Society of Human Resource Management, and CSEA, the largest NYS union. Representatives sit on workgroups and communicate individually with these entities. NY TCP Cessation Centers and the NYSSQL in collaboration with the NYS Office of Health Insurance Programs and the NY Health Plan Association have an initiative with NY health plans to enhance tobacco use cessation communication to their providers and members, focusing on evidence-based resources that make a significant difference in improving quit rates. 60% of the plans joined the initiative and are actively expanding on the initial relationship to improve access to cessation benefits. The NYS inclusive strategic planning project brought all of the above together to participate in focused dialogue to identify actions and evaluation methods that will achieve specific objectives within the larger NYS ActionToQuit strategic plan.

## **ENVIRONMENTAL SCAN**

The NY Tobacco Control strategic plan supports a variety of evidence-based strategies to increase tobacco cessation, including making cessation interventions a standard part of health care in New York State. This strategy is supported by Cessation Center activities, services offered by the NYSSQL, and public health communications to motivate tobacco users to quit.

Survey data from the New York Adult Tobacco Surveys (ATS) show improvements in several key cessation outcomes. Over time, more NY smokers reported intentions to quit and recent quit attempts. In 2008, these numbers were significantly higher than national averages. An increasing number of health care providers in New York assist tobacco users with quit attempts. Awareness of and calls to the Quitline have increased over the past 5 years. Data from surveys of health care organizations and providers show increased awareness of cessation resources in NYS and improvements in guidelines to identify and treat tobacco dependence. Analyses link program efforts to improvements in key cessation outcomes. Provider cessation interventions are positively related to quit attempts. NY residents who were aware of cessation media messages were more likely to make quit attempts, as were those who called the Quitline. Higher cigarette prices were associated with a greater likelihood of making quit attempts.

NY TCP funds 19 Cessation Centers across the state to facilitate implementation of systems within health care organizations and provider offices to screen patients for tobacco use and prompt providers to offer advice and assistance to quit. To complement this effort, the NYSSQL provides cessation support and services to help NYS residents to quit. NY uses public health communications, including mass media, public relations, and media advocacy to motivate tobacco users to quit. Many of these communications initiatives promote the Quitline. Additionally, NY TCP supports efforts to reduce out-of-pocket costs for effective therapy, increase the unit price of tobacco, and promote smoke-free environments.

New York has started working with the Medicaid program to increase access and expand coverage for smoking cessation counseling and pharmacotherapy. Medicaid will provide reimbursement for two 90-day courses of prescription smoking cessation medication and over-the-counter nicotine patches and gum. As of January 2009, pregnant smokers could receive up to six counseling sessions annually.

The other strategy for reducing out-of-pocket costs for effective cessation treatment is to provide free NRT starter kits. In addition to distributing NRT through the NYSSQL and Quitsite, NY TCP has distributed NRT through substance abuse treatment programs and cessation centers as they work on systems change with federally qualified health centers. The distribution of NRT through substance abuse treatment programs began in September 2007 to help facilitate OASAS programs' transition to smoke-free facilities and grounds required by

the Office of Alcoholism and Substance Abuse Regulation 856, implemented in July 2008. In this setting, NY TCP is the payer of last resort for NRT.

From surveys conducted with NYS health plans, we know the gap in NY's effort is with health plan provided and employer supported comprehensive tobacco use cessation treatment benefits. NYS health plans are not fully covering comprehensive cessation services for all their members. NYS plans vary in coverage, co-pays, and duration of benefit. If benefits exist, providers, purchasers, and health plan members are not always aware of benefit and access to coverage. Smoking cessation benefit information is not always easy to understand, as there is no single defined, comprehensive standard. Since the cessation benefit is usually a purchased plan benefit, employers may opt out of purchasing services for their employees.

## **EVALUATION OF THE PROGRAM**

The NYS Smokers' Quitline at Roswell Park Cancer Institute (RPCI) led the initiative and partnered with the NY Tobacco Control Program (NY TCP), and American Cancer Society to build on working relationships with NY health plans, health plan groups, major employers, employer-based groups, Society of Human Resource Management, and NYS Office of Health Insurance Programs (OHIP). The inaugural group reached out to potential executive committee members with a letter; five affirmative responses launched our membership. During the first executive committee meeting each member agreed to contact at least one other individual/organization to recruit to the executive committee. Using existing relationships we brought together a comprehensive group to guide this project. An at-a-glance document for communicating the project and an outline of the executive committee member role and time commitment were tools used for recruiting members. By clearly stating the project goals and process plus outlining committee member commitment, we recruited a diverse statewide membership of individuals who were truly engaged in the strategic planning process.

We distributed a RFP for a consultant; however no respondents possessed the skill set we learned was needed once we began to work on the grant. Originally, it was believed a facilitator was necessary to keep the executive committee and the strategic planning process organized and on task. The executive committee quickly fulfilled these needs by dividing regionally to organize each summit. Grant administrators assumed the role of leading the strategic planning process and providing guidance to committee members with summit logistics. Members were aware of the community resources available and maximized grant funds when possible. The division of roles worked well and did not overburden committee members who worked on smaller time-bound projects. Grant consultants leveraged existing relationships to contribute to alliance building activities, solicit earned media, and facilitate speakers and small group activities at each of the three summits.

Executive committee members were assigned to one of the three summit planning sub-committees based on their proximity to Buffalo, Albany, and NYC. Each small group secured a summit venue, food, and other necessary logistics. Sub-committees conducted weekly phone meetings about one to two months prior to the summit. Lessons learned were applied to the subsequent summits so that by the third summit the greatest challenge was the cost of venue and food in NYC. To overcome this barrier we solicited summit sponsors and exhibitors to defray the NYC summit costs. Executive committee members utilized existing relationships to recruit summit participants. The database of all three summit registrants contained over 200 people and included about forty health plans and fifty-five employers, with the remaining representing non-profit organizations, NY TCP contractors, and local health departments. A Save-the -Date (with registration link) was e-mailed to stakeholders about one month prior to the first summit. Executive committee members

forwarded the invitation to additional contacts and reached out to employers and health plans with phone calls and e-mails to encourage participation in summit discussions. Follow up e-mails were sent about one month before the second and third summit. Overall, we exceeded our goal of recruiting at least 150 summit participants and we were pleased with the diversity and level of participation of attendees. Summit evaluations positively highlighted speakers and provided the opportunity to meet and network with people.

With only one day to extract stakeholder input at each summit, the executive committee drafted a strategic plan outline (only goals and measurable objectives) that served as the foundation for the summit agenda and speaker talking points. Strategic plan actions were provided by summit participants during goal specific discussions. To be most productive at each summit, attendees prepared for productive small group discussions by visiting a section of the Quitline website (<http://www.nysmokefree.com/PageView.aspx?P=70&P1=7020>) devoted to this initiative. Educational resources such as Podcasts, links to other relevant websites, executive committee information, and reading material were provided and registrants were encouraged to review the online materials



*Patricia Bax (left), Marketing Coordinator and Ann Wendland (right), Program Manager, New York State Smokers' Quitline*

before the summit. At each summit, poster boards demonstrating need, content, and benefits of comprehensive cessation treatment for health plan members and employees was used to further educate and reinforce summit messages. Summit speakers focused their talking points on one of the three goals [Please see summit agendas and strategic plan for more detail]. As part of the strategic planning process, facilitators engaged summit participants in three small group strategic planning discussions, one per goal area. There were about 8-10 small groups consisting of 6-8 participants, each came together three times during day of the summit to provide input on actions that would achieve the NYS ActionToQuit goals

and objectives. Almost the entire day was dedicated to working in small groups. Participants were pre-assigned to groups, indicated by a number (1-10) on their nametags. After each speaker, the summit facilitator directed all tables to start working in small groups to identify realistic and achievable goal and objective actions. To the extent possible, each group was composed of people from a cross-section of expertise, geography, and professions.

Summit small group discussions provided the actions within the NYS ActionToQuit strategic plan. This extensive document is overwhelming with the large number of actions and required focus. The executive committee assessed each goal and chose those actions that were achievable in the next year to be included in the published strategic plan. The long version will remain intact; however the abbreviated version will be the working document to guide NYS' year two ActionToQuit initiative.

Post summit online chats provided the executive committee with insight on what policy and practice change

actions participants have taken since the summit. The first chat combined registrants from the Buffalo/Western New York (WNY) Summit and the Albany Summit, creating an opportunity to expand the network at each individual summit. Chat participants shared strategies they had initiated since attending the summits. One participant implemented a policy change at her company, offering incentives for employees to quit tobacco use. Another participant from the WNY summit linked up through the chat with an Albany Summit participant to discuss assisting tobacco users with mental health issues by increasing access to cessation resources.

A NY TCP project that will supplement year two grant activities is the development and production of a Tobacco-Free Worksite Toolkit to encourage employers to refer tobacco using employees to the Quitline, to integrate tobacco cessation into worksite wellness initiatives, and to ensure that employee health plans provide coverage for tobacco cessation counseling and medications. The toolkit will be distributed to at least 500 NYS based businesses with policy change technical assistance provided to businesses by NY TCP local level contractors.

## **CHALLENGES**

Some initial concerns involved the recruitment of stakeholders to participate in the executive committee. This concern was short-lived as partners employed their existing relationships to recruit members from diverse organizations to secure a robust committee.

With a strong executive committee in place, a consultant needed to be hired. In the search to identify the most qualified candidate, what was believed necessary consultant qualities/skills was not true once the project was underway. A consultant who would do more than facilitate and guide a project was necessary. We needed a marketer, facilitator, project manager, resource solicitor, creative individual, and more all in one person(s). In revising our initial plan, we consulted with colleagues and others to determine the desirable qualities we needed in our consultant. Rather than selecting someone who worked on past NYS strategic planning projects, we recognized this project was different and required a unique approach and multiple skills to be successful.

Another challenge was the hosting of the NYC summit. This summit was more challenging to organize than the other two due to venue and food costs, limited meeting locations, competing events, and transportation issues. Options for a summit location in the NYC/metro area that fit within our budget were non-existent. To overcome this barrier, with the assistance of our executive committee, we solicited summit sponsors and exhibitors to defray the costs. However, we did not have sufficient funds to cover the costs of recording the NYC Summit and we needed to transcribe key points of the event.

Competing priorities at RPCI led to the website development taking longer than expected. In the interim, the committee continued to gather resources and record Podcasts. The approach to educating stakeholders changed from using the website exclusively to supplementing it with poster displays at each summit. This proved to be a much better approach to generating strategic plan actions during the small group discussions since we could refer summit participants to the displays that complimented speaker talking points.

A final challenge and hurdle was time management. Hosting three summits generated additional logistical issues that deterred time away from implementing additional creative ideas, summit promotion, outreach, and expanding on technological opportunities.

## LESSONS LEARNED

The ActionToQuit grant provided the catalyst to advance the NYS Tobacco Control's tobacco cessation efforts of working with employers, employer groups, and health plans. The most positive aspect of this project was the creation of networking opportunities and connections that most likely would never have occurred without this grant.

There are several key lessons we learned in New York State through the implementation of our project. First, we realized early on in the process that we could not orchestrate our efforts alone if we wanted to reach our goals and objectives. We needed to reach out to existing partners and to potential partners who could enhance our existing resources and skill sets.

Secondly, we identified communication as being key to our success and we needed a vehicle to convey our information. With everyone's busy schedules, we determined the most efficient mechanism for communication was a website accessed through the NYSSQL. This site allowed for us to build and expand our information as the project advanced and as we identified more resources. In addition, the site is an easy reference tool, provides quick access, introduces site users to the expansive range of NYSSQL services, and affords us increased capacity for year two and beyond.

### **KEY LESSONS LEARNED**

- You can't do it alone!
- Develop a website for communication.
- An organized & diverse executive committee is a must.
- Schedule bi-weekly conference calls and create a standing agenda.
- Delegate tasks with a checklist and form sub-committees.
- Build on each person's strengths.

Thirdly, in scanning the landscape of the state, we realized disparities exist across regions in reference to the needs and progress in addressing tobacco cessation. This led us to conclude an organized and diverse executive committee was a must and it needed to be representative of the entire state. With this type of committee, the individual members brought their own unique network of contacts to the project.

We needed to establish structure with our committee, so we scheduled bi-weekly conference calls and created a standing agenda. Minutes were recorded, which assisted us in staying on track with our tasks and providing accountability for assigned responsibilities.

After hosting three distinct summits coming up with the expansive list of tasks, a key lesson learned was the need to delegate tasks, maintain checklists, and create sub-committees. In turn, the sub-committees

held conference calls to accomplish details in each of the individual summit planning processes. Through the executive committee and sub-committees, we were able to capitalize and build on each person's strengths. This focus ensured tasks were accomplished and individuals felt more invested in the project.

Although the grant provided initial funding, it was evident that if we were to host three successful summits, we needed to leverage our existing funds and resources. This leveraging of funds included thinking outside of the box, doing things such as hosting the Western New York Summit at a television studio, where costs to record the event were minimal.

Another lesson learned was the need to anticipate unexpected costs. This lesson led us to tap into our creativity and reach out to committee members to assist in problem solving. With some ingenuity, we were able to scale down expectations, while still managing to achieve our implementation.

Our final lesson learned was not to make assumptions. This included assumptions about individuals' knowledge base, levels of understanding, completion of tasks, and most of all that everything will go as planned. This will be a lesson we will certainly take with us in year two.

## **LOOK TO THE FUTURE**

With year two ActionToQuit funding, New York plans to continue dialogue with summit attendees through conversations, Quitline website, on-line chats, and e-mails to facilitate implementing its strategic plan. NYS' strategic plan and a complimenting employer toolkit (printed with NYS TCP funds) will be printed and distributed to NYS based health plans and employers.

A new partnership will develop with NYS tobacco control program (TCP) community contractors to conduct outreach and provide technical assistance at the local level to health plans and employers. This partnership will be coordinated with the NYSSQL and will utilize existing TCP and Quitline resources, including materials and tools found on the NYS ActionToQuit website: (<http://www.nysmokefree.com/PageView.aspx?P=70&P1=7020>).

NYS TCP will develop a plan and establish workplan requirements for TCP community programs in all 62 NYS counties to work with employers, health plans, and umbrella groups. An action within the plan will be for the community programs to host local (county level or 2-3 counties) meetings with employers, health plans, and other stakeholders to establish working relationships, provide an overview of the strategic plan and toolkit, and provide technical assistance on implementing both.

The TCP will work with other DOH chronic disease programs (obesity, healthy heart, etc) to coordinate and expand contractor outreach with employers at local level. Outreach will include promotion of the Quitline's online cessation program to increase enrollment and enhance existing cessation benefits.

To compliment work at the local level, the Quitline will provide mini-grants to health plans and employers who are working toward achieving one or more strategic plan objectives.

A total of nine mini-grants will be distributed: Seven for a single entity and two for collaborative efforts by employers and health plans. Mini-grant applications will first be made available to health plans and employer groups who attended one of the three summits. Interested parties will then be asked to submit an application, which will be reviewed by the ActionToQuit Executive Committee, who will also determine criteria for final selection. Promotion for the mini-grants will be conducted via the NYSSQL website and through scheduled chats.

Our hope for the long term impact of this project is to ensure that all tobacco users have access to comprehensive cessation treatments

The new strategic plan will cover the period 2011 – 2013 and chart a path for New York to achieve its 2014 adult smoking prevalence goal of 12 percent. The new strategic plan will set the framework for a) cessation treatment coverage provided as a core benefit with NYS health plans; and b) all commercial and Medicaid insured NY smokers to have access to cessation treatment for their quit attempt.

*Case Study Focus:*

# **VIRGINIA**



*Establishing Tobacco Cessation Treatment in Mental Health/Substance Abuse Programs*

## **OVERVIEW**

Prevention Connections (PC), Alliance for the Prevention and Treatment of Nicotine Addiction (APTNA) and American Cancer Society (ACS) formed a team to develop the Virginia Partnership for Tobacco Cessation (Partnership). Although there are various cessation activities happening in Virginia, historically, there has not been a successful effort to develop a plan to coordinate them. Additionally, there is a significant gap in these efforts in the area of behavioral health (mental health and substance abuse services), a population which has an extremely high smoking rate.

The particular interest of the planning team was two-fold: to increase the availability and coverage for cessation treatment for the population at large as well as through publicly-funded health plans and to connect a broad range of mental health professionals and systems to tobacco addiction treatment.

These main goals are critical to success because health care reform will impact cessation treatment broadly and in publicly-funded health plans; employers and insurers have individual contracts with Virginia's Quitline provider, creating an opportunity for collaboration and maximizing resources; and tobacco addiction treatment is significantly lacking among Virginia's behavioral health care providers and systems.

### **Objectives:**

- Convene a one-day summit for key representatives from various sectors interested in tobacco use cessation by September 30, 2010.
- Form sub-groups from summit participants and host two follow up meetings to further develop strategic plan components for inclusion in a state plan by January 31, 2011.
- Finalize and disseminate state plan to all summit participants and other interested stakeholders by February, 2011.

## **ENVIRONMENTAL SCAN**

There are two primary means by which cessation is promoted in Virginia. First is the statewide quitline, funded through the Department of Health. The quitline offers very limited services; i.e. single session phone counseling for adults and pregnant girls on Medicaid and the opportunity to enroll in a multiple-session phone-based protocol for tobacco users who are uninsured or on Medicaid. Total annual funding for the quitline is approximately \$250,000 and services do not include cessation medications. The budget does not allow for promotion of the quitline; therefore, callers must learn about it through providers or posters in health clinics. Over the last 19 months, a total of 3,586 tobacco users have called the state quitline. These are almost all Medicaid/uninsured callers, only reaching about 0.25% when the state target is 2% and national "goal" is a minimum of 5%. The second method to promote cessation is through provider training on USPHS evidence-based interventions with accompanying assistance on policy change. The Virginia Department of Health contracts with APTNA, a non-profit group and key collaborator on this project, as a sole provider of clinical and systems-based resources for reducing tobacco use. Its annual funding is about \$100,000; therefore, training is provided on a request basis only, until funding is depleted. Some training has been provided to safety net providers, yet there exists further opportunity to conduct statewide training for these organizations.

Although Medicaid does cover FDA-approved medications and limited cessation counseling, it is not widely promoted to patients in literature provided to them, nor are Medicaid providers encouraged to discuss cessation with them. There is general confusion among providers and the public as to the services and

medication that are covered under the state Medicaid program.

In the area of mental health and substance abuse treatment, little occurs in the tobacco cessation arena. Providers in community services boards (CSBs) do not routinely incorporate tobacco cessation in treatment plans. Yet, CSBs are the main entry point in communities throughout the state for mental health and substance abuse treatment. CSBs service both youth and adults. Providers in other settings such as the community health centers and free clinics also do not focus on tobacco cessation. It is surmised these facilities and personnel have not received training in this area and view other treatment needs as a higher priority. One notable achievement in the area of mental health occurred in 2008 when public mental health residential facilities adopted smoke-free campus policies statewide and provided training for professionals.

A general and very large barrier to cessation treatment is the lack of health insurance coverage for treatment services and medications. Few employers provide cessation services and among those that do, it is often limited to one treatment plan and time period. This limits treatment access for smokers who often need 5-7 attempts to be successful with cessation.

Safety net providers, including those focused on behavioral health, are positioned to reach lower-SES populations as well as those with behavioral health issues. These are critical populations to reach since 50-80% of low SES and people experiencing mental health or co-occurring mental health/substance abuse disorders smoke, while little attention has been given to these groups.

## **EVALUATION OF THE PROGRAM**

Virginia was fortunate to have its initial team comprised of PC, APTNA and ACS; all of which had extensive experience in tobacco control and/or cessation. APTNA in particular had a wide network of behavioral health and healthcare providers/systems, PC had lists of major employers in Virginia and ACS was aware of resources to obtain lists of insurers through the Virginia Association of Health Plans. Additionally, these organizations offered in-kind support valued at \$12,900.

Upon award notice, PC contracted with the Virginia Commonwealth University Performance Management Group (PMG) to facilitate the three Partnership meetings planned as part of the grant activities. PMG expressed interest in being part of the planning team for the meetings to become more familiar with the expectations and to develop appropriate agendas for each one. This was very beneficial.

PC had the opportunity during the planning cycle to be assigned a Virginia Governor's Fellow to assist with the project. This individual was instrumental in identifying and gathering contact information for various potential participants, especially in employer and insurer groups.

The three primary partners began with the twenty organizations that provided letters of support/commitment to attend the summit. This was the foundation of the Partnership and additional organizations and companies were invited to attend. These included major insurers such as Anthem, Optima and the state Medicaid office; health systems in all major metropolitan areas including Sentara, Bon Secours, HCA, VCU Health System, Carilion, INOVA Health, UVA Health System, Eastern Virginia Medical School, Virginia Community Healthcare Association, and free clinics; provider associations included the Medical Society of Virginia, the Virginia Academy of Pediatrics and local pediatric societies; mental health providers including community services boards (CSBs), outpatient treatment centers, the Daily Planet Healthcare for the Homeless, and residential facilities; and public entities included the Virginia Department of Health and Virginia Department of Behavioral Health and Developmental Services (including their community services boards). Additionally, PC obtained a database of the top 50 employers in the state and also invited them. From these groups, approximately 60 people attended.

The partner organizations and summit facilitator met several times to discuss the purpose of the summit, generate a comprehensive list of employers, insurers and government and non-government organizations, prepare a draft agenda and assign responsibilities to each person. During the discussion the group emphasized the need to have a “hook” that would attract people to attend. This was important, because the Partnership wanted leadership in each of these groups to attend. The planning team selected the topic of health care reform and the impact it would have on cessation services. A speaker on this topic was invited to participate at the opening of the summit.

Personal letters were sent to all prospective participants. They were asked to RSVP in order to determine the number of facilitators needed and verify whether there was a balance of the sectors represented, including healthcare employees, employers, insurers and behavioral health specialists. As RSVP’s came in, the planning team contacted individuals within sectors that were under-represented to encourage participation. Special attention was given to behavioral health groups since this was a priority for Virginia’s plan.

The Partnership met twice after the initial summit. At the subsequent meetings, overall goals were developed as well as objectives related to them. Activities and key leaders for each, along with some metrics, were developed.

Virginia’s plan was to host a large summit, followed by two meetings of those interested in continuing as part of the Partnership. The initial summit included approximately 60 people, representing a variety of groups. Prior to the summit, the planning team distributed a survey provided to the Partnership for Prevention to all individuals who responded they were coming. This information proved useful in determining how much background needed to be provided at the summit prior to workgroups beginning to brainstorm major goals.



*Marge White (left), Project Director, Prevention Connections, and Janis Dauer (right), Executive Director, Alliance for the Prevention and Treatment of Nicotine Addiction*

The Prevention Connections board chairman welcomed the participants and explained the purpose of the summit. This was followed by a presentation of the current status of cessation activities in Virginia. A guest speaker concluded the morning with an overview of the potential impact of health care reform on cessation services.

In the afternoon, the facilitators divided the group in two, with representatives from each sector in each subgroup. The facilitators further divided their groups into working groups and asked each to develop goals they felt were important to further the progress of nicotine addiction treatment in the state. The workgroups then reported out and gained consensus on the goals that were a priority. The facilitators then brought all participants back together and repeated this process. The summit concluded with consensus on the major goals of the Virginia state plan. Participants were asked to express their interest on an evaluation form or by providing a business card before they departed.

The second meeting included about 30 people. Invitations were extended to the initial mailing list and some new people came to the second meeting. At this session, one facilitator attended and worked through a similar process to identify objectives and activities that could be included in the plan. At the end of the meeting, she posted large paper with the goals listed on them and asked the groups to use sticky notes to list the various activities and post them under the appropriate goal. The full group then reviewed the goals to ensure the objectives and activities were in the appropriate category. The group also decided there were really two main goals: policy change and education/training.

At the third meeting there was similar participation. The facilitator divided the group into two groups by having individuals self-select which they preferred to be in. The groups then developed additional activities, identified responsible parties and defined metric where it was feasible. The group felt they had a good draft that was not quite complete and agreed to meet again in April, 2011. At this meeting they will finalize the plan and begin planning for implementation of the activities.

## **CHALLENGES**

The main challenge faced was engaging employers and insurers to attend. Although the 50 major employers in Virginia were invited, none attended. Employers were only represented by those who also represented another sector and only two insurers attended.

There was concern the Department of Medical Assistance Services (Medicaid) might not send a representative based on past attempts to engage them in cessation activities.

An individual from one organization (who was a different representative than the first meeting) pulled some others from the education group during the second meeting to discuss harm reduction and make it a separate priority goal. The individual was very vocal in expressing her views on the topic. This topic is very debated in tobacco control and was placed in the education group as an issue to explore. In fact, the Quitline Coordinator for the Virginia Department of Health sent a follow-up email stating he would withdraw his participation if this became a separate priority goal and the small group continued.

One of the insurer groups' staff knew representatives from some of these employers. They were mainly from HR areas. It was suggested that the Partnership try to engage employers through a sub-group focused on educating the public about the state Quitline and demonstrating to employers their separate contracts with the Quitline vendor could be leveraged to provide services for more people from the general public while also engaging more of their employees. An initial planning meeting took place in January to strategize about this approach.

The planning team requested the Executive Director of the Virginia Foundation for Healthy Youth extend the invitation due to their relationship in state government. This was a successful approach and the Commissioner of the Medicaid office attended.

The planning group discussed the situation about harm reduction after the meeting. It was decided two approaches were needed. First, the APTNA director contacted the director of the organization that sent this representative. She explained the situation and noted the larger group had assigned the topic of harm reduction to the education group. She also provided honest feedback that their representative was somewhat disruptive to the meeting and jeopardized commitment from other key partners. This feedback was appreciated and the organization sent a different and more appropriate representative (from an organizational role standpoint) to the third meeting. Additionally, the Partnership project director addressed the "reconsolidation" of assessing harm reduction as a strategy to the education group. These straightforward approaches were successful in eliminating any "heated debate" that would distract from the larger purpose.

## **LESSONS LEARNED**

- During the proposal process, ask organizations for letters of support including their commitment to attend the summit. This was helpful in building a base of organizations that were aware of the purpose and could later help promote the summit to others.
- Begin the invitation process for your summit as early as possible to allow for follow-up contacts.
- Use relationships and networks to engage participants. The Executive Director of APTNA, a key partner, knew many of the behavioral health contacts. She personally called each of them to explain more about the summit and to gain commitment to attend.
- Use a facilitator. The key partners had some priorities going into the meeting, so a neutral party was helpful to gain ideas from the entire group. Additionally, having representatives from the key partners in the smaller workgroups was very useful to answer questions and/or provide information on the status of current cessation activities in the state.
- Having multiple sessions proved very helpful to flush out more details for the strategic plan. The first summit meeting produced goals and allowed the participants to discuss their merits and prioritize them. Subsequent meetings generated more discussion on timelines for these and objectives and activities for each. While observing this multi-session approach, it was apparent the participants' enthusiasm and commitment to implement the plan grew with each meeting.
- Identifying a "champion" for major activities will be a critical factor as implementation begins. Although the agenda included a speaker on health care reform which was thought to be critical to attract employer groups, this strategy did not work. However, participants did find it useful to get an overview of some of the requirements that would be implemented under reform. This further helped in developing some strategies.
- It was challenging to make the first summit meeting relevant to each participant and/or their organization to create enough enthusiasm for all to return. The result was fewer attendees at subsequent meetings but probably those much more interested and committed to the process.
- It was important to emphasize this was not just a plan on paper, but a strategic plan that would be implemented. Having some funding for year two was important to demonstrate the seriousness of moving these activities forward.

## **LOOK TO THE FUTURE**

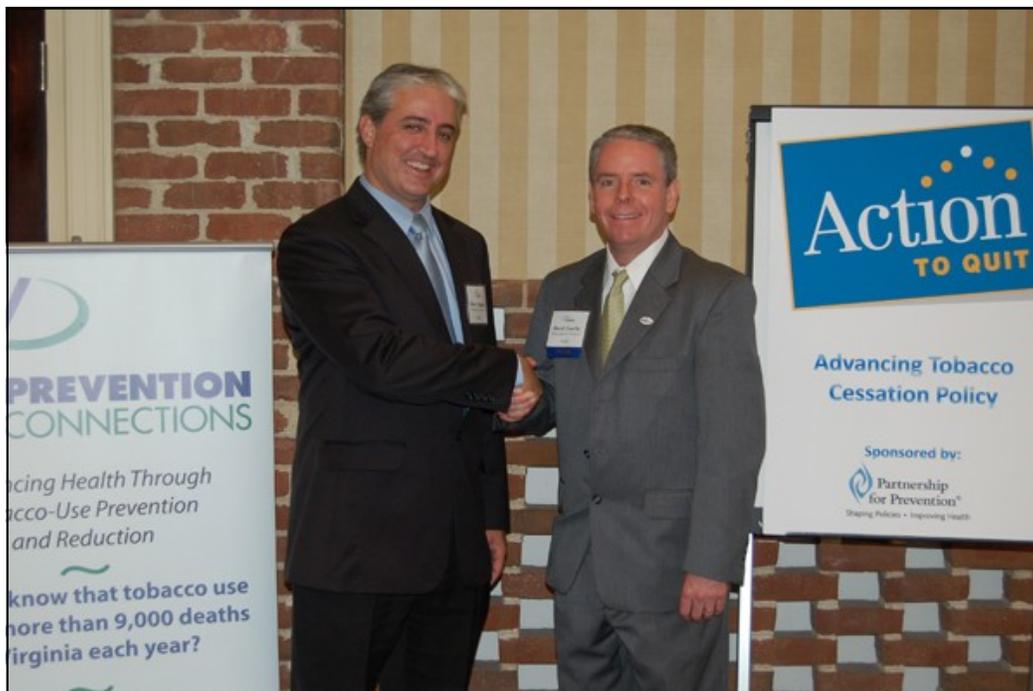
Virginia's Partnership is scheduled to meet in April, 2011. As in the first project period, the Partnership will continue to engage the highest level of leadership within these various sectors, but will also expand its reach to others that can effectively implement portions of the plan.

Two sub-groups of the Partnership will be formed to focus on policy initiatives, and increasing the use of the state Quitline and coordinating cessation treatment in behavioral health settings.

One key goal identified in the first summit meeting was to coordinate resources around the state Quitline to broaden its reach and impact. Insurers suggested convening a sub-set of the group and inviting the employer and insurer groups that have individual contracts with Free & Clear, the Quitline contractor. This will be one major strategy in this continuation grant period. A planning meeting with two insurers (who knows the

groups with private contracts for Quitline services) will be held to develop a timeline and process to engage these groups in a meeting. Prevention Connections will work toward having the 23 groups collaborate to maximize their resources to broaden the reach of the Quitline. Additionally, PC will engage VDH to discuss their funding from CDC and how to leverage that to further enhance services or use it to promote the Quitline statewide.

The second key goal from the meetings was to assist behavioral health providers in understanding the importance of addressing tobacco use among persons with mental health and/or substance abuse issues and to



**Danny Saggese** (left), Chairman, Board of Directors, Prevention Connections and **David Zauche** (right), Senior Program Officer, Partnership for Prevention

involve them in implementing strategies within their respective systems to increase cessation services. Initial objectives and strategies developed by the Partnership included offering trainings for large groups to gain their buy-in to the concept and offering further provider training on techniques to use to assist this population group with tobacco treatment as part of their overall treatment process. Community Services Boards (CSBs) that provide behavioral health treatment at the community level will be a focus area for implementation of this

portion of the strategic plan. The Director of the DBHDS Office of Behavioral Health Services has attended the Partnership meetings and wishes to have the group assist with exploring ways to implement policies in an effective manner.

With a growing emphasis on tobacco use cessation (e.g., the new Medicaid and Medicare coverage and health care reform's focus on effective preventive health treatments and the integration of primary care/behavioral health) and the need to reduce healthcare expenditures, the Partnership will continue to work on strategies around primary care. There was significant discussion at the summit about methods to increase implementation of the United States Public Health Service (USPHS) evidence-based interventions for the treatment of tobacco use and dependence (the 5 A's and 5 R's) by providers in public and private health systems, encourage all providers to discuss treatment options with patients, and promote Quitline services. These methods will continue to be developed in the coming year, with additional outreach to the medical and dental community.

**We hope that the long term impacts of our project will:**

- Create a larger network of organizations committed to advancing policy throughout the state
- Promote the need for additional funding for the state Quitline through the state legislature
- Engage employers/insurers funding the state Quitline to collaborate and maximize resources to further the reach
- Gain commitment at the state level to have Medicaid providers assess for and treat tobacco use as a standard of practice with their patients
- Provide training sessions throughout the year to healthcare, behavioral health and dental providers to assess and treat tobacco use as a standard of practice with their patients
- Integrate tobacco addiction treatment into the standard treatment protocol within the behavioral health system
- Engage behavioral health advocates/consumer groups to push for standard tobacco addiction treatment

*Case Study Focus:*

# **NEW ENGLAND**



*Replicating the Massachusetts Medicaid Comprehensive Cessation Benefit Throughout New England*

## OVERVIEW

Led by the American Lung Association of New England, six New England states joined together in March 2010 in an intensely collaborative effort to share resources, strategies, and lessons learned to work towards a common cessation policy goal. The goal of the initiative was to duplicate the heralded Massachusetts Medicaid cessation benefit throughout New England – and, in Massachusetts, to extend that same benefit to state employees covered by the Group Insurance Commission (GIC) and people insured through the Commonwealth Connector (CC) – a health insurance plan for uninsured individuals who are not Medicaid-eligible but require some public assistance to afford health insurance. The success of the Massachusetts Medicaid (MassHealth) cessation benefit is unprecedented. Not only is the benefit coverage comprehensive but the benefit has been well promoted among Medicaid smokers in order to ensure high utilization. As a result, 40% of all adult smokers on Medicaid have accessed cessation benefits since implementation, a statistic unparalleled elsewhere. Equally compelling, hospitalizations for heart attacks were cut in half for MassHealth members who utilized the cessation benefit. Key strategies were to include:

- A regional summit;
- State summits held in each of the six New England;
- Technical assistance and coaching provided by M+R Strategic Services to each of the state teams;
- Strategic media outreach;
- Briefings with lawmakers and key decision-makers; and
- Crafting and implementing a detailed action plan in each of the states with an eye towards building capacity in Year 1 and enacting policy changes in Year 2.

## ENVIRONMENTAL SCAN

At the beginning of the grant period, cessation Medicaid coverage (and GIC coverage in Massachusetts) was as follows:

✓ = Covered      ⚠ = Coverage Varies      ✗ = Not Covered

| State    | NRT gum | NRT patch | NRT nasal spray | NRT inhaler | NRT lozenge | Varenicline (Chantix) | Bupropion (Zyban) | Group counseling | Individual counseling |
|----------|---------|-----------|-----------------|-------------|-------------|-----------------------|-------------------|------------------|-----------------------|
| CT       | ✗       | ✗         | ✗               | ✗           | ✗           | ✗                     | ✗                 | ✗                | ✗                     |
| MA       | ✓       | ✓         | ✓               | ✓           | ✓           | ✓                     | ✓                 | ✓                | ✓                     |
| MA – GIC | ⚠       | ⚠         | ✗               | ⚠           | ⚠           | ⚠                     | ⚠                 | ✗                | ⚠                     |
| ME       | ✓       | ✓         | ✓               | ✓           | ✓           | ✓                     | ✓                 | ✗                | ✓                     |
| NH       | ✓       | ✓         | ✓               | ✓           | ✗           | ✓                     | ✓                 | ⚠                | ✓                     |
| RI       | ⚠       | ⚠         | ⚠               | ⚠           | ⚠           | ⚠                     | ⚠                 | ✓                | ✓                     |
| VT       | ✓       | ✓         | ✓               | ✓           | ✓           | ✓                     | ✓                 | ✗                | ✗                     |

Even in the states that “look good on paper” (e.g. Vermont which covers all medications and Maine which covers everything except group counseling), utilization is exceptionally low and specific barriers to access have been identified.

One of the major challenges at the outset of this project has remained – a lack of data to measure the number of Medicaid smokers and the current utilization of cessation benefits. Only Massachusetts has had access to reliable, in-depth data about smoking rates and utilization. Below is a break-down of the state-specific data and its availability.

- **Connecticut:** Data not available.
- **Maine:** 27% of adult smokers covered by Medicaid received pharmacological treatment for tobacco use in FY10 and 4.1% received tobacco treatment counseling services;
- **Massachusetts:** Prior to the implementation of the MassHealth benefit, the smoking rate was 38.3% for the population. In the first 2.5 years of the Medicaid cessation benefit, 41% of Medicaid smokers utilized the benefit and the smoking rate dropped to 28.8%;
- **New Hampshire:** There are no actual numbers regarding access and utilization;
- **Rhode Island:** Working on gathering data from Medicaid;
- **Vermont:** No utilization data is available. However, survey data has found that 40% of Medicaid recipients believe they are eligible for free or reduced cost NRT while 48% do not know whether they have any covered cessation benefits.

Some of the current gaps in services that have been identified include:

- **Connecticut:** There is no funding for Medicaid coverage of cessation. Very little counseling or smoking cessation services available in the state.
- **Maine:** The benefits are not promoted to doctors or to clients due to lack of funding. Co-pays for medications limit access.
- **Massachusetts:** GIC does not offer any cessation benefit while CC plans offer a benefit with some counseling and some medication but not a comprehensive benefit.
- **New Hampshire:** Medicaid provides a good benefit for counseling and medications, but the Medicaid pharmacies do not always have the medications in stock and Medicaid doctors are not well educated as to what benefits exist for patients.
- **Rhode Island:** There is no inventory of cessation providers which means that neither physicians nor consumers know where counseling services are available. Although there is no utilization data, anecdotal evidence indicates that utilization is quite low.
- **Vermont:** There are prescription preauthorization requirements which pose a barrier to access as well as a co-pay which can be a barrier to access. Survey data has indicated that many Medicaid recipients are unaware of the available cessation benefits, and there are currently no promotion activities to increase awareness.

Across the states, there are a few common gaps:

- Smoking rate and cessation utilization data is inconsistently available, inconsistently tracked, and not readily available to advocates;
- Advocates have strong relationships with the Departments of Health but, in most states, advocates do not have the same strong relationship with the Medicaid office;
- Lack of state tobacco control funding to promote awareness of available benefits among consumers.

## EVALUATION OF THE PROGRAM

**Inputs:** In terms of funding, the only planned source of cash support was from the ActionToQuit funding and that was received. There were several sources of in-kind support that were expected and all were received; these included staff time and support from the American Lung Association, the American Heart Association, and the American Cancer Society. Technical assistance and coaching were provided by M+R Strategic Services as planned (via monthly team planning calls as well as one-on-one calls with individual states as requested and needed), and this was made possible through the ActionToQuit funding. In terms of “people resources”, we planned to convene a regional planning team with representatives from each of the six states as well as a broad-based state planning team in each state. The regional planning team came together as expected, and included the tobacco coalition coordinator in each state, state and regional representatives of American Lung Association, American Heart Association, and American Cancer Society, and members of the state tobacco coalition. The state planning teams were not as diverse as planned, lacking participation of key players in several states. For example, Maine and Vermont were the only states that forged a strong working relationship with the Division of Medicaid, and Connecticut was the only state that had participation from healthcare providers through the Connecticut Pediatric Association. Even in terms of state summit participants, the attendees were not as diverse as planned and lacked active involvement of key constituencies including healthcare providers, the business community, and the faith community.



*Diane Pickles (left), Vice President, M+R Strategic Services, Karla Sneegas (middle), Executive Director, Indiana Tobacco Prevention & Cessation, and Edward Miller (right), Vice President, Health Promotion and Public Policy, American Lung Association of New England*

**Activities and Outputs:** A regional summit was held on October 19th with 40 attendees and all 6 states well represented. The summit was intended to be an information and strategy sharing session that would enable each state to hear first-hand about the Massachusetts experience of Medicaid cessation benefits and have an opportunity to ask questions and share ideas with one another in preparation for their individual state summits. Dr. Lois Keithly, Director of the Massachusetts Tobacco Cessation and Prevention Program and Ayesha Camaarts, former Policy Director of MassHealth gave a keynote presentation about the creation of the Massachusetts cessation benefits as well as how it was rolled out and promoted to providers and consumers. This presentation was filmed, and a copy was provided to each state so that they could view the presentation at their state summit. While all would have preferred to have Lois and Ayesha “live and in person” at their state summits, we recognized that resources and time just did not allow for that but that the expertise shared was essential to each state. Following the regional summit, each state planned to convene a state summit.

After assessing their state environment and specific needs, several states diverged somewhat from what they originally envisioned for their summits. Vermont chose to convene a small intimate group of key stakeholders for some specific and action-oriented dialogue. Massachusetts determined that a summit was not going to help them achieve their objective of moving the GIC and CC forward without first having high-level private meetings with leaders at each institution. New Hampshire put the brakes on convening a summit while they work to secure active and meaningful conversations with the state Medicaid office. Below is a brief overview of the activities and outputs in each state:

- **Connecticut:** Snow has forced the cancellation of the state summit twice. The newly scheduled summit date is February 14th. In preparation for the summit, the planning team has met weekly by phone or in person. They have gathered and utilized information from Massachusetts and have focused on process, advocacy, benefits and outcomes of their policy endeavors. The summit is being co-hosted by a state lawmaker.
- **Maine:** The summit was held on December 8th and there were approximately 20 attendees. Two primary issues were the focus of the summit: (1) how to create contracts with managed care organizations; and (2) how to promote existing benefits.
- **Massachusetts:** As previously stated, Massachusetts decided not to convene a statewide summit but to focus their energies on high level meetings with the GIC and CC. They have been successful in securing meetings with the director of CC and have been meeting twice per month for the last two months. It has been much more difficult to connect in person with the director of the GIC, although they continue to try. The coalition has filed legislation to mandate cessation benefits for all those who are insured by these two entities.
- **New Hampshire:** The New Hampshire planning team launched a planning process that included outreach to the Commissioner of the Department of Health as well as the Medicaid Director. They have been unsuccessful thus far in securing meetings with the Medicaid Director and feel they should put the summit on hold until after such a meeting can be secured. They have, however, identified several barriers to cessation for Medicaid recipients and are working hard to secure data about smoking rates and utilization which has been difficult to access.
- **Rhode Island:** Rhode Island's summit is planned for March 11th and a large and diverse group of stakeholders were invited. To date, 44 individuals have registered to attend.
- **Vermont:** Vermont held preliminary meetings with key players and then held a small, intimate summit with a targeted invite list of stakeholders on November 3rd. Participants identified several specific outcomes including a commitment from the Department of Vermont Health Access (Medicaid office) to meet internally to address barriers to the current benefit.

No state has yet begun to write a state action plan. M+R Strategic Services will provide technical assistance and coaching in year 2 to assist states in doing so.

## CHALLENGES

While each state has had its own unique challenges (described below), there are several universal challenges that have been faced by all:

1. ***Inadequate funding for tobacco control advocacy activities:*** while this grant provided a stipend to each state, the funding was relatively small. In addition, the state coalitions are already operating on reduced budgets without reduced advocacy agendas. Accordingly, there is an ongoing struggle to meet objectives and goals with the resources available. Because the coalitions' time and resources are spread quite thin, the states struggled to devote adequate time for outreach and recruitment of key stakeholders beyond those with whom they are already engaged.
2. ***Struggling state budgets and dramatically reduced funding for tobacco control:*** while certainly not unique to New England, this was definitely a challenge that each of the six states expressed throughout the initiative. There are really two sub-issues to this challenge. First, the fiscal climate makes it very difficult to motivate lawmakers to add any new benefit, service, or program that is not already contained in the state budget. Second, there is little money allocated to the states' tobacco control programs to enable cessation promotion activities.

Specific challenges that were identified by individual states were as follows:

- **Connecticut:** Lack of funding for tobacco control;
- **Maine:** None.
- **Massachusetts:** Difficulty securing a face to face meeting with the director of the GIC.
- **New Hampshire:**
  - Lack of a coalition coordinator;
  - Personality conflicts among coalition partners and differences in philosophies;
  - Inadequate "people power" – not enough organizations to participate in the effort;
  - Loss of all state tobacco control funding in 2003.
- **Rhode Island:**
  - Difficulty accessing data;
  - Communications among partners.
- **Vermont:** Overall budgetary and economic climate.

With the exception of New Hampshire and Massachusetts (which chose not to do a summit), each of the states was able to overcome these challenges in order to plan and execute a summit as planned. We believe that the challenges of inadequate funding for tobacco control and struggling state budgets will, however, impact their ability in year 2 to develop and implement a state plan.

## LESSONS LEARNED

Each of the six states identified different lessons that might be helpful for other states:

### Connecticut:

- The advocates in Connecticut have experienced several legislative “stalls”, i.e. their pending bills have been stalled in the legislature even though they looked promising. Their advice is to create legislative networks and continually work those networks.
- Create broad-based partnerships.
- Determine goals and key players and the actions that are necessary to achieve them

### Maine:

- Their summit felt too brief. There was not enough time for all stakeholders to contribute and suggested that break-out sessions may have made that easier.
- Involve the Medicaid staff in presenting at the summit, either as a panelist or presenter – to speak to their area of expertise as this brings a higher level of insight and understanding.

### Massachusetts:

- The data that was available through the Department of Public Health and MassHealth has been essential. The MassHealth data illustrated short turnaround with positive results – 46% decrease in acute myocardial infarction over an 18 month period and a cost savings of over \$10 million. This robust return on investment has been very compelling. For the CC and GIC plans, the number of smokers is fewer than Medicaid so the cost savings will be less but the Medicaid data has still been compelling to make the return on investment argument effectively.
- In order to secure benefits, it might be easier and faster to approach the issue administratively first (i.e. enact a benefit through an Executive Office regulation) before filing legislation.

### New Hampshire:

- The project timeframe was too brief.
- Good communications are essential to pull together a good planning team.

### Rhode Island:

- The regional summit in October was critical.
- Having American Heart Association, American Lung Association, the American Cancer Society, and the March of Dimes actively involved was essential because they bring expertise, connections, and resources.
- The project time frame was too short.
- Lack of staff resources is difficult.

### Vermont:

- A good, small core group is more effective and efficient. However, participants should be decision-makers and people who can effect change.
- It is important to have the Medical Director and Medicaid representatives at the table.

## LOOK TO THE FUTURE

Plans for 2011 include the following:

1. ***Develop a packet of compelling communications materials:*** While each of the six New England states varies in their specific area of policy focus, there is a shared need for communications materials that will make the case for why states should invest in helping low-income smokers quit. Although New England has a rich history of progress in tobacco control policy, low-income smokers have traditionally been considered “hard core”, difficult to reach, difficult to motivate and difficult to help successfully quit smoking, according to the New England Partnership for Smoking Cessation Policy . The Massachusetts experience, however, makes an extremely compelling case for investing in these “hard core” smokers who are actually quite motivated to quit smoking and are successful if provided with low or no cost cessation services and pharmacotherapy. M+R Strategic Services will create materials to help make this case. This packet is likely to include a series of one-page fact sheets, sample letters to the editor and op-eds, and a short video that can be sent via email to lawmakers and other key decision makers. In order to build momentum, these materials will be branded to the New England Partnership for Smoking Cessation Policy to convey that this is an issue being addressed across all six of the New England states.
2. ***Presentations to influential New England associations and groups:*** As each state group is working to implement its state plans, we believe that targeted outreach and advocacy to select the convening of New England associations and organizations will fuel local efforts. M+R Strategic Services will identify potential New England associations and speaking engagement opportunities. We will then develop a presentation about the New England Partnership for Smoking Cessation Policy that emphasizes both the health and economic reasons to invest in Medicaid cessation coverage and deliver this presentation to 2-4 targeted regional groups. Possibilities include the following:
  - New England Governor's Conference
  - The New England Partnership for Health Equity
  - New England Society for Healthcare Strategy
  - New England Consortium
3. ***Spokesperson training sessions:*** M+R Strategic Services will train individuals with real stories about the difficulties and the successes of quitting smoking to be spokespersons for the states. The goal will be to train these individuals to be effective spokespersons for Medicaid cessation policy and become persuasive advocates for both lawmakers and the media. State partners will be responsible for recruiting individuals to participate in the training.
4. ***Technical assistance to states:*** We will convene bimonthly regional conference calls during which state teams can share strategies, challenges, and successes. In addition, M+R will provide technical assistance to each of the states in the following areas: (1) review of their state plans, providing feedback and suggestions; (2) identifying potential partner organizations; (3) developing grassroots recruitment strategies; (4) advising around media messaging and strategies; and (5) trouble-shooting around the implementation of their state plans.
5. ***Development of state-specific action plans:*** Each of the six states will work to craft a state action plan for increasing access to cessation services for the Medicaid population as well as the GIC and CC plans in Massachusetts. The six states have identified the following as their hopes for long-term impacts of the project:

**Connecticut:**

- Insurance coverage for all;
- Determine how to remove barriers that exist;
- Increased access to treatment;
- Create partnerships with merchants
- Increase the number of people who can provide cessation services by increasing availability of training programs.

**Maine:**

- Reduce smoking rates.

**Massachusetts:**

- Decreased heart attacks (shorter-term);
- Decrease in lung cancer (longer-term);
- Increase cost savings in both areas.

**New Hampshire:**

- Reduce the fragile population of state smokers – those currently on Medicaid and their children (shorter-term);
- Get private insurers to provide comprehensive cessation benefits (longer-term).

**Rhode Island:**

- Reduce smoking rates.

**Vermont:**

- Have sustained funding for programs, including cessation;
- Acquire Medicaid as a partner and secure agreement on reimbursement policy;
- Increase and improve promotion of cessation benefits.

## Comments

The information in the case studies covers activities that took place between April 2010 and January 2011. All of the states have since made additional progress on their summits and strategic plans. The grantees began Year 2 of the ActionToQuit program in February 2011. Updates on their progress will be available on [www.actiontoquit.org](http://www.actiontoquit.org).

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